EXPRESSIONS OF CARING

BY CONTEMPORARY SURGICAL NURSES:

A PHENOMENOLOGICAL STUDY

BY

CAROL L. ENNS

A Thesis Submitted to the Faculty of Graduate Studies in Partial Fulfillment of the Requirements for the Degree of

MASTER OF NURSING

Faculty of Nursing
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ABSTRACT

Care and caring forms the basic core of nursing actions. It has been stated that caring is nursing and nursing is caring (Leininger, 1988). The two are inseparable when theories attempt to describe what nursing is. Yet, many nurses today find it difficult to define caring behaviors. Nurses are frustrated in the workplace, as a variety of internal and external forces have rapidly changed the delivery of nursing care in the past 10 years. Nurses attempt to uphold standards of nursing practice in an environment that often defeats the essence of nursing – caring. The lived experience of nurses who work in acute care surgical units was explored in this study in an attempt to better describe the phenomenon of caring in the context of contemporary practice.

Ten nurses participated in this research study. A semi-structured interview guided the conversation between the researcher and the participant. Participants were encouraged to share their expressions of caring in the context of the new practice environment. The data that was gathered provided a rich description of the meaning of caring and the positive and negative expressions that impacted on the nurses ability to care. The data were analyzed using van Manen's (1997) phenomenological guide to human research.

Meaningful expressions by the participants were extracted from the data to formulate four major themes, supported by the essential structures. Research findings were congruent with the nursing literature and the five perspectives of the sensitizing framework by Morse, Solberg, Neander, Bottorff, and Johnson (1990). Recommendations for nursing practice and administration, education, and research are made based upon the study results.

ACKNOWLEDGEMENTS

Generally, a thesis brings closure to Graduate Studies; however, this thesis is not the end, but the beginning of a passage through the nursing profession that I have chosen. I have several people that I would like to acknowledge.

I would like to thank the Faculty of Nursing, University of Manitoba, for providing me the opportunity to explore a program in which I was able to tailor to suit my personal, educational, and professional needs.

I am grateful to the ten participants who eagerly and graciously gave up their time to share their expressions and stories with me. It was an honor and a privilege to be a part of your world. Thank you.

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Great Works are performed, not by strength, but by perseverance.

Samuel Johnson

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CHAPTER ONE: BACKGROUND, PROBLEM, AND PURPOSE

Introduction

Caring is considered a universal phenomenon and has been extensively used as a nursing term, describing all aspects of patient and nursing care. Caring is commonly referred to in the nursing literature, yet, it remains a concept which is nebulous, ambiguous, subjective, and multidimensional. A clear understanding of the underlying attributes of caring from the perspective of the practicing nurse is important to accurately conceptualize what caring is. The concept of caring in the nursing discipline lacks clarity, as scholars and philosophers continue to strive to determine a solid definition. Leininger (1988) states that nurses have not examined the term caring, and since it is used routinely in nursing, caring experiences should be expressed by nurses. Perhaps, the most relevant and real portrayal of caring is derived from the nurses' perspective. The general aim of this study is to understand the expressions and experiences of caring in contemporary surgical nursing practice. The purpose of this chapter is to provide background information regarding the concept of caring. A statement of the problem and the purpose of this research will be delineated to assist in understanding the importance of this study.

Background

A Personal Story

I remember working an evening shift on an acute care surgical unit in a tertiary hospital. I was assigned to care for eight patients. It was a typical busy evening. My shift consisted of the usual nursing tasks: multiple dressing changes, the administration of intravenous medications, monitoring vital signs, receiving post-operative patients and an attempt to settle patients for the night. After my shift, I arrived home. I quickly slid into my bed, pleased to be able to rest my feet and my mind. However, my mind began to race as I reflected upon the events of the evening. Did I complete my charting? Did I settle all the patients for the night? Did I say good bye to my patients? Did I administer all the medications and complete the dressing changes? I sat up in bed in a panic. I called out: "I can't remember their faces." It was then, for the first time in my nursing career that I realized something was wrong. I could not remember the faces of the eight patients who I had cared for. I had spent eight hours with a group of people and I could not picture in my mind what they looked like. I came to a conclusion that I had nursed a body attached to an intravenous pole and I had attended to a variety of abdomens with large white dressings. I had monitored vital signs and felt pulses on wrists. I saw the patient, but did I nurse the patient? Did I make eye contact with my patients? Do I remember our conversations? Were people attached to the highway of intravenous tubing? I was so busy attending to necessary procedures, nursing tasks and interventions that I lost sight of the patient. Is this what surgical nursing is all about today? Did I provide the care I wanted to give; care that I was taught to give; care that is essential to my practice in what I do and who I am? Is caring really the essence of nursing? Does caring have a place in contemporary surgical nursing practice?

My personal journey in surgical post-operative nursing has provided me with countless occasions to practice nursing care in the clinical setting. Being a part of health restoration after surgical intervention has been a very rewarding experience. To provide care for a patient from a dependent state immediately following surgery, until the time the patient is well and ready for discharge, is an immeasurable feeling of contentment. However, I have experienced, witnessed, and listened to many colleagues who have expressed frustrations with the care they were unable to provide to their patients; care they wished they could give; care that they were taught to give. Today, nurse-patient relationships occur within a shorter time frame and the quality of nursing care is often questioned by the nurses' themselves. Understanding what caring means in contemporary

surgical practice from the surgical nurses' perspectives, is the essence of this research study.

Nursing as Caring

Bishop and Scudder (1991) discuss nursing as caring. Caring has two interrelated meanings: concern for others and taking care of others. The authors explain that the nurse expresses concern for the patient by giving excellent nursing care, whether or not the nurse actually likes the patient as a person. Nursing is a practice through which human concern is expressed through expert nursing care. Bishop and Scudder (1991) refer to Heidegger's (1962) ontological interpretation of caring. In his work, caring is a human way of being-in-the-world. It is not separate from the world. This perspective by Heidegger (1962) enhances caring as being a fundamental attribute of nursing and that caring is considered a human trait.

Nursing as Practice

According to Bishop and Scudder (1991), nursing has identified itself as a caring practice. Recently, nursing scholars have begun to re-think nursing as an applied science, related to a shift in nursing education from a diploma program to a university degree. Bishop and Scudder (1991) argue that nursing could not be a science as science aims at knowing the truth, whereas practices, such as nursing, promote and maintain good health. Nurses in the surgical setting apply science in nursing in order to bring about health restoration. Application of theoretical knowledge and principles in clinical practice are important in order to execute nursing skills and decision making, however, personal qualities of the nurse and the dimensions of caring are important as well. "Nurses need to know science in order to practice, but they show their 'smarts' and 'guts' in the exercise

of their caring practice" (Bishop and Scudder, 1991, p. 5). Nursing can be considered a human science. Nurses must be able to relate to others on a personal level and be sensitive toward others feelings. I agree with the perspective of Bishop and Scudder (1991) that the caring aspect of nursing is important, particularly in light of expanding technology. The authors continue that technological reform may lead nurses to lose sight of the meaning of caring that is inherent in nursing practice. As technology increases, the need for human touch increases.

Contemporary Surgical Nursing Practice

My research involves the world of the nurse who works on an acute care surgical unit. For the purpose of this study, surgical nursing is defined as: pre-operative and post-operative nursing care given by registered nurses on general surgical wards and day surgery units.

In the past 10 years, technological advancements have increased at a rapid rate. Medical technology and equipment once reserved for intensive care and specialty units have made their way into general medical and particularly, surgical units. Nurses often wonder if there is actually a patient amidst the highway of tubing and multiple machines to which they are attached. Equipment was introduced into nursing intending to save time and labor for nurses and improve monitoring for patients with complex interventions. In reality, monitoring equipment and changing tubing has increased the workload for many nurses. Pressure for professional nurses to achieve technological proficiency may de-emphasize caring as a central expression of nursing. However, technological competency is also considered a component of caring. As caring has yet to be universally defined, caring can be expressed in many ways.

Nursing shortages are apparent locally, nationally, and internationally. Nurses often work their shift "short staffed," and are expected to pick up the additional work. Nurses are, more often than not, required to care for more patients than usual during their shift, with a heavier reliance on assistance from support staff. The fast pace of a surgical unit and the reduced number of nursing staff shortens the time the nurse can spend with the patient. Nurses on surgical units describe this type of nursing as the "conveyor belt" approach.

In order to quantify nursing care in an institution, patient classification systems were developed and are currently utilized by nursing administrators to assess workloads and staffing ratios based upon patient occupancy and acuity. Radsma (1994) explains that a classification system fails to reflect the amount of time required to provide quality care, the time to offer emotional support or reassurance to the patient, and time to attend to unpredictable events during the shift or to render patient teaching. If we cannot see care, but only experience it, how can care be quantified through a classification mechanism?

Radsma (1994) continues that nurses themselves contribute to the invisible work of caring. Nurses in general are quick to minimize their work in self-depreciating statements such as "It wasn't much" or "I'm just doing my job." An article by Buresh and Gordon (2000) encourages nurses to speak about their work and what they do. The authors explain that what we know about nursing we have learned from nurses, when nurses talk about their experiences. I agree that nurses need to tell the world what they do and how they experience the work of nursing care.

Individual patient acuity level has increased. Today, inpatients present with complex medical problems and illnesses and are increasingly more acutely sick. The expanded life expectancy of the population has led to numerous chronic conditions, thereby increasing the complexity of care. Advanced surgical interventions are being performed on patients, many who are elderly. Post-operatively, these patients require continuous and vigilant monitoring. A wide range of knowledge and skill is required to effectively manage the multiple needs of patients. The nurse is left with little time to teach the patient; to spend time with the patient; and to care for the comprehensive needs of the patient.

Ambulatory surgical care facilities and short stay surgical programs have become common in the past decade. Patients are discharged from the hospital sooner. The nurse is required to provide discharge information for the patient in a reduced amount of time. For example, many mastectomy patients are discharged home with surgical drains, which they must attend to while at home. The nurse must assess the patient's level of understanding and determine if the patient will be able to care for their particular needs. The nurse delivers information about wound care, signs and symptoms of infection, nutrition, and drainage care in a very short time frame. Once patients are discharged, hospital beds quickly become occupied by fresh post-operative patients, whom the nurse has never met before. Patients are no longer admitted to the surgical unit the day before surgery. Therefore, there is no baseline to assess the patient. There is no time to get to know the patient and understand and identify their needs and determine their capabilities. The fast pace of contemporary surgical nursing demands keen physical and psychosocial assessments, as well as honed teaching skills.

Leveck and Jones (1996) explored the relationship between the practice environment on medical and surgical units and the quality of nursing care. Nurse's in this study perceived higher levels of job stress and lower levels of professional job satisfaction, than nurse's who work on specialty units, such as critical care. The nurses were less satisfied with the quality care they were able to give and the lack of time they were able to spend with their patients. A study by Tillman, Sayer, Corley, and Mark (1997) investigated how stressors in acute care impact on the nurses' ability to provide patient care. Nurses described a loss of control in an environment where patients have complex needs, while resources and support services are fewer. These studies indicate a direct relationship between the nurses' perception of quality nursing care and stress in contemporary practice. Both studies also suggest that job satisfaction may have a direct relationship on the retention and recruitment of nurses.

Nurses are required to assess, be efficient, delegate work, and provide teaching in a hurried world. Traditionally, caring has been an important aspect of nursing. Nursing upholds caring as an ideal. Present working conditions often limit the opportunity to care, and the survival of care in the profession is tenuous. Do nurses value caring as fundamental to their practice? Do the time constraints of contemporary nursing hinder caring as a central domain of nursing? What is the meaning of caring from the perspective of nurses in clinical practice today?

Definitions of Care and Caring

Care (as a noun or a verb): a small, common, yet influential four-letter word. According to Gaut (1983), "caring" as a word comes from the Old English and Gothic words, *carian* and *kara* or *karon*. *Kara,* means grief, lament, sorrow, or bed of sickness. Early use of care (c.1000) included concern, heed or attention as in "attend to this matter with due care." Around 1400, the term indicated a sense of protection. Care has a long history in societies outside of the nursing profession. Nursing and care are synonymous within the nursing domain. How can such a small word create so much attention in the discipline of nursing?

The elusiveness and complexity of caring in the literature is vast and confusing. There is no agreement of the definition of caring, the components of caring, or the process of caring. Caring remains a poorly defined concept in nursing practice and education. The use of the term care, caring, care plans, and nursing care are often interchangeable and difficult to distinguish in the nursing literature (Morse, Solberg, Neander, Bottoroff, & Johnson, 1990).

Dictionary definitions. The use of care as an abstract noun or caring as a verb (to care) compounds the difficulty. The Canadian Oxford Dictionary (1998) was consulted in order to obtain definitions of care and caring. Care as a noun implies trouble, anxiety, serious attention, be cautious, protection, ensure safety of. Caring as a noun is a process of looking after or providing for someone or something. It is the provision of what is needed for health or protection. Caring is also described as compassionate or considerate, especially toward other people. As an adjective, caring is feeling or showing care and compassion, a caring attitude; or relating to professional, social, or medical care. The

term care is expressed in Roget's Thesaurus (1993) as solicitude or concern; attention; object of watchful regard; to be solicitous, attentive, to be inclined or to have regard. To care for is to attend, like, love, nurse, protect, and watch over.

Non-caring. In the nursing literature, the term non-caring is presented as the opposite or absence of caring. The term non-caring is frequently cited in quantitative nursing research studies, comparing caring and non-caring behaviors demonstrated by a nurse from the perspective of the patient (Larson, 1981; 1984; 1987; Cronin & Harrison, 1988; Larson & Ferketich, 1993; Gooding & Sloan, 1993; Halldorsdottir, 1996; Greenhalgh, Vanhanen, & Kyngas, 1998). Non-caring or uncaring behaviors identified by nursing students include not giving of self, not meeting patient's needs on time and not providing comfort (Chipman, 1991). Roach (1987) explains that caring may often be more obvious by its absence, rather than its presence.

Overuse of the Word Care. In everyday language the terms care and caring are often over used. Roach (1987) discusses the human act of caring and its uniqueness to nursing. The author describes the term caring as a popular phrase in commercials, advertisements, posters, and billboards. People care for one another; the auto mechanic cares; the grocer cares and there are numerous products for skin care. The University of Manitoba and the Faculty of Nursing invite potential students to "Prepare for a Career in Care" as part of a major recruitment strategy. Care is often used to express apathy, i.e. "I don't care." Roach (1987) explains that "real care" is not ambiguous and neither is apathy, therefore, they are distinguishable. Yet, the term caring has been difficult to discern.

Theoretical Perspectives of Caring

Caring has been identified as the essence of nursing (Leininger, 1988; Watson, 1988). Madeleine Leininger and Jean Watson are two leaders in nursing who have devoted their careers to studying the evolution of caring as central in the discipline. Leininger (1988) states that caring is the central and unifying domain for the body of knowledge and practices in nursing. She developed a transcultural nursing theory of human care. The assumptions of this theory include the belief that human caring is universal, while the expression of caring does vary among cultures. Caring patterns are transculturally derived. Leininger's (1988) work is grounded in anthropology. Human beings are inseparable from their cultural background and social structures. Leininger (1991) states that "care refers to actions and activities directed towards assisting, supporting, or enabling another individual or group with evident or anticipated needs to ameliorate or improve a human condition or way-of-life, or to face death" (p.46).

Jean Watson (1988) has established that human caring involves values, a will, and a commitment to care. She has focused on the philosophic and spiritual basis of caring and sees caring as the ethical and moral ideal of nursing. Watson (1985) provides a theoretical definition of care. Watson (1985) describes caring as a value and an attitude that has to become a will, an intention, or a commitment, that manifests itself in concrete acts (p.32).

Roach (1987) maintains that "caring is not simply an emotional or attitudinal response. Caring is a total way of being, or relating, of acting; a quality of investment and engagement in the other – person, idea, project, thing, or self " (p.2). She further delineates that nursing as a discipline identifies caring as the core to practice.

Benner and Wrubel (1989) claim that caring is primary in the relationships between caring, stress and coping, and health. The authors continue that caring sets up the condition that something or someone (the nurse) outside the person matters and creates concern. Caring enables nursing practice to occur. "Caring is essential if the person is to live in a differentiated world where some things really matter, while others are less important or not important at all" (Benner & Wrubel, 1989, p. 1).

Swanson (1991) derived and validated through phenomenology, a middle-range theory of caring from the patient's perspective. The theory consists of five processes: knowing, being with, doing for, enabling and maintaining belief. "Knowing" is the effort to understand the life of the other. The care provider attempts to truly know the other willingly. "Being" with is being emotionally present to the other, sharing feelings, being available and conveying a presence. "Doing " for is assisting the other in total care or supporting self-care practices. "Enabling" facilitates the other through unfamiliar events, providing knowledge, helping growth and validating feelings. Finally, "maintaining belief", is sustaining faith in the other's capacity to overcome adversity. Swanson (1991) concluded with a definition of caring: "Caring is a nurturing way of relating to a valued other toward who one feels a personal sense of commitment and responsibility" (p. 165).

The theoretical perspectives provided have conveyed a general understanding of the concept of caring in a manner that fits with the theory developed. Although the theories discussed are renowned, caring remains underdeveloped as a concept and has not been clearly stated (Morse et al, 1990). It is important to explicate a perspective of caring that is relevant to clinical practice.

Statement of Problem

Caring is used repeatedly and abundantly in the nursing literature. Perhaps it is somewhat overused or worn out, to a point where it has been neglected, abandoned, or pushed aside in contemporary views of what nursing is and what nursing is not. Does caring have a place in contemporary nursing? What is the experience of caring from the perspective of the surgical nurse? Enriched descriptions of caring from the perspective of the nurse will serve to fully articulate the caring phenomenon. The lack of qualitative research studies from the nurses' perspective heightens the need to address this problem, particularly in surgical nursing. Most of the literature on caring was developed and published in the 1980's. Since that time, the majority of nurse-research studies have focused on the concept of caring from the patient's perspective, further developed into theory. A theory of caring from the perspective of the nurse does not exist.

Statement of Purpose

The purpose of this research was to describe the expressions and experience of caring ascribed by surgical nurses. The nursing literature offers broad theoretical and philosophical definitions of caring, with a lack of practical definitions from the nurses' perspective. There are also limited expressions of caring in medical and surgical nursing practice in the current nursing literature. The view of the nurses' perspective of caring is central to this study. Investigating the narratives of caring from those individuals who experience this concept will assist to understand the substance of caring. This knowledge will allow the unseen expressions of caring to be described as an experience.

Research Questions

The research questions generated for this study included:

1. What are the expressions and experiences of caring from the surgical nurses' perspective?
2. What meaning do these experiences have for the nurses?
3. What made the experiences positive or negative?

Assumptions

The following assumptions have been made:

1. Caring has been defined in many ways in nursing – one sole definition of caring does not exist. However, this is not considered a limitation in the exploration of caring, as I believe that all caring definitions, from the perspective of the nurse, offer an aspect of truth.
2. Caring from the perspective of the nurse has not been explored fully. Stories and expression of caring from the nurses who provide direct patient care are vital to the conceptualization of caring.
3. Although nurses and researchers report and write that caring is the essence of nursing, many nurses working in clinical practice today recognize that caring may not be as valued, given current economic restraints, expanding technology, nursing shortages and increased patient acuity.
4. I have personally experienced occasions where I felt frustrated at the end of my shift that I was unable to provide nursing care in a caring manner. This relates to a variety of factors that exist in the current arena of nursing practice.

Since I do not claim that my experience is novel, I assume that many colleagues will relate similar occasions and reflections.

Sensitizing Framework

Polit and Hungler (1999) explain that conceptual frameworks or schemes, represent a less formal attempt at organizing phenomena. Conceptual frameworks deal with abstract concepts, such as caring. Frameworks help to provide a conceptual perspective and are less structured than theories. I have chosen a conceptual framework that offers perspectives on caring in clinical practice. Given the abundance of definitions and theories about caring, it is important to maintain a clear perspective for this research project.

Morse and associates (Morse, Solberg, Neander, Bottoroff, & Johnson, 1990) developed five epistemological perspectives of caring. The perspectives help to clarify the complexity of caring in the literature. The conceptualizations were derived from the work of various nurse theorists and researchers, and compiled by the above authors. This conceptual framework was chosen for two reasons. First, it is a clear, broad framework, which expresses conceptualizations of caring in five categories and provides a conceptual context for this study. Second, the conceptual framework is not only based on the perspective of the patient, but also the nurse. Theoretical frameworks, such as the classic work of Leininger (1988) and Watson (1988), base their theories from the perspective of the patient or the nature of the nurse-patient relationship. Since the purpose of this study is to articulate expressions of caring from the perspective of the nurse, it is important to provide a conceptual framework that represents nurse-centered perspectives.

Morse et al (1990) present five categories of caring, which are described in the following way. Caring as a Human Trait, caring as a Moral Imperative, caring as an Affect, caring as an Interpersonal Interaction, and caring as a Therapeutic Intervention.

As a Human Trait, caring is innate and is seen as a motivator for nursing actions. It is considered part of human nature. It is perceived to be a basic characteristic that forms the foundation of human society and it is essential component of being human. The ability to care is influenced by a variety of factors including past experiences and culture.

Caring as a Moral Imperative or ideal describes caring as a fundamental value and an adherence to one's own individual integrity. The moral imperative includes maintaining dignity and respect to patients as people. Caring enables the nurse to identify what actions in the nursing care are appropriate.

Caring as an Affect explains that the nature of caring signifies empathy and concern and that intimacy between the nurse and patient is identified. Caring as an emotion and a feeling must be present in order for the nurse to care. It must be sincere. The art of nursing is expressed through creative forms, which express caring. The nurse puts her/him self into the patient's position.

Caring as the Interpersonal Interaction, suggests that this is the essence of caring, When caring occurs, the nurse and the patient have communicated, trusted, respected, and committed to each other.

Finally, caring as a Therapeutic Intervention includes a variety of task and procedural activities. Specific caring actions identified in this category included: listening, teaching, touch, being there, assisting with pain, spending time, and observing. Clinical competencies are also considered a therapeutic intervention.

Morse et al (1990) conceptualizes caring to include both humanistic traits and physical behaviors. The concept of caring expands beyond expressive/affective human attributes and includes clinical competency and nursing knowledge. I believe that through the expressions and articulation of nurses' experiences in the clinical setting, scientific knowledge, clinical competency and expressive behaviors will assist to describe a rich and encompassing conceptualization of what caring is and what it means.

Summary

In summary, I have discussed the background information, theoretical perspectives, and the foundation for this study by describing caring and the concept of caring, as it is described in the nursing literature. A portrait of the difficulties and issues that have been experienced by nurses working in contemporary surgical practice has been outlined. The statement of the problem and the purpose of the study have been identified. Research questions have been derived and posed. Finally, I have presented the sensitizing framework that was used in this study. The following chapter presents a review of the nursing literature.

CHAPTER TWO: LITERATURE REVIEW

Introduction

The terms caring and nursing are strongly associated with one another in the nursing literature. Quantitative studies about caring have examined nurse behaviors that characterize caring, as those most important and least important. Comparison of nurses' and patients' perceptions has also been quantified. Patient perception has been valued in the past, particularly in the 1980s when quality assurance tools were introduced to measure quality of nursing care in institutions. Caring has been revered as the heart and essence of nursing, however, the expressions and experiences of caring from the perspective of nurses is limited. The need to implement studies of caring from the nurses' view is important, since there have been so many changes that have influenced the way in which nurses are able to deliver care in the clinical setting. The purpose of this chapter is to review nursing research that has attempted to quantify and qualify caring, and to analyze past literature that supports the need to reframe caring from the perspective of the nurse (see Table I, p.18).

Table I – Summary of Quantitative and Qualitative Literature on Caring

Quantitative Literature		Qualitative Literature	
Nurse Perspective	**Nurse/Patient or Patient or Family/Student Perspective**	**Nurse Perspective**	**Nurse/Patient or Patient Perspective**
Larson (1986) -oncology nurses' perceptions of caring using the CARE-Q instrument **Dyson (1986)** -nurses' caring attitudes/behaviors -Repertory Grid Technique **Morrison (1989)** -nurses' perceptions of caring -Repertory Grid Technique **Parsons, Kee & Gray (1993)** -peri-operative nurse perceptions of caring -Caring Behavior Assessment (CBA) **Greenhalgh, Vanhanen & Kyngas (1998)** -nurse caring behaviors -psychiatric/general duty nurses	**Larson (1981)** -CARE-Q instrument to measure nurse caring behaviors **Larson (1984)** -cancer patients most/least important nurse caring behaviors -CARE-Q instrument **Larson (1987)** -cancer patients'/ nurses' perceptions of caring behaviors -CAR **Mayer (1987)** -replicated Larsons' (1984) study -most/least important caring behaviors by cancer patients -CARE-Q instrument **Cronin & Harrison (1988)** -importance of nurse caring behaviors perceived by patients E-Q instrument **Harrison (1991)** -Professional Caring Behaviors -perceptions of families/nurses in Hospice setting **Mangold (1991)** -nurses vs nursing students perceptions of caring **Von Essen & Sjoden (1991)** -caring behvaiors by patients and nurses on medical/surgical units	**Forrest (1989)** -described nurses experiences of caring **Clarke & Wheeler (1992)** -using phenomenology, studied nurses' perceptions of caring **Nelms (1996)** -clarified common meanings of caring by nurses **Williams (1998)** -caring perspective of surgic **Idvall and Rooke (1998)** -surgical nurses' perceptions of important nursing care/quality nursing care al nurses **Bertero (1999)** -nurses shared positive/negative experiences of caring using phenomenology	**Drew (1986)** -patients' perceptions of caring **Chipman (1991)** -nursing students described caring/ non-caring behaviors **Milne & McWilliam (1996)** -nurses/patients resource time as caring time -included other health care professionals

Table I – Summary of Quantitative and Qualitative Literature on Caring

Quantitative Literature		Qualitative Literature	
Nurse Perspective	**Nurse/Patient or Patient or Family/Student Perspective**	**Nurse Perspective**	**Nurse/Patient or Patient Perspective**
	Huggins, Grady & Kohut (1993) -studied emergency department patients' perceptions of nurse caring behaviors **Larson & Ferketich (1993)** -measured important nurse caring behaviors by adult medical-surgical patients utilizing the Care/Satisfaction Questionnaire (CARE/SAT) **Von Essen & Sjoden (1993)** -psychiatric patients/ staff perceptions of caring **Wolf, Riviello Giardino, Osborne & Stahley Ambrose (1994)** -Caring Behaviors Inventory (CBI) -patients'/nurses' perceptions of caring **Watson & Lea (1997)** -Caring Dimensions Inventory (CDI) - nurses'/ nursing students' perception of caring **Larrson, Peterson, Lampic, von Essen & Sjoden (1998)** -studied nurse and patient measurement of important caring behaviors using the CARE-Q instrument **Marini (1999)** -Caring Behavior Assessment (CBA) -determine older adults' perceptions of caring behaviors		

Quantitative Measurement of Caring

Larson (1981) developed the Caring Assessment Instrument (CARE-Q) to measure important nurse caring behaviors. The CARE-Q tool has been utilized repeatedly worldwide (personal communication, P. Larson, November, 1999). Larson (1984) identified the perceptions of patients with cancer (N=57) of most and least important nurse caring behaviors applying the CARE-Q instrument. Patient's valued technical and psychomotor skills as most important, while listening and comforting were regarded as least important. Larson (1986) conducted a study of the perceptions of caring behaviors by nurses (N=57). Nurses in this study identified behaviors of listening, touching, and talking as most important. The above studies suggest that professional nurses' perceptions of caring and patients' perceptions' of caring are not in agreement. Mayer (1987) replicated Larson's (1984) study comparing oncology nurses' (N=28) versus cancer patients' (N=54) perceptions of caring behaviors, which supported Larsons' (1984) work. Mayer's (1987) study found that cancer patients identified technical competencies as most important, while nurses perceived comfort measures as important.

Larson (1987) compared cancer patients' (N=57) and nurses' (N=57) perceptions of important nurse caring behaviors. In this study, nurses' perceived comforting and trusting relationship behaviors most important, while in contrast the patients' perceived nurses behaviors that demonstrated monitoring and being accessible as most important. There was a significant difference in perceptions between the two groups.

While Larson (1981; 1984; 1986; 1987) and Mayer (1987) focused on specialty oncology units, von Essen and Sjoden (1991) studied the importance of nurse caring behaviors perceived by hospital patients (N=81) and nursing staff (N=105) on general

medical and surgical units. The CARE-Q tool was applied and results are consistent with the previous authors. Von Essen and Sjoden (1993) continued their work and measured psychiatric patients (N=61) and staff perceptions (N=63) of caring. In this study, there was a distinct difference in rating importance of caring behaviors. While inpatients considered the cognitive and the task-oriented aspects of caring as important, staff revealed the emotional aspect of caring as most important.

A study by Morrison (1989) identifies the significance of some nurses' self-perceptions of caring. Using a Repertory Grid Technique, the nurses were asked to consider the elements of "ideal self as carer" on a seven-point rating scale. All nurses (n=25), perceived shortfall in their own performance and satisfaction with care giving. Nurses' set very high standards and their expectations were not realistic in the practice setting.

Utilizing the Care/Satisfaction Questionnaire (CARE/SAT), Larson and Ferketich (1993) reveal that hospitalized patients rated technical aspects of nursing as important caring behaviors. The participants (N=268) were hospitalized, adult, medical-surgical patients who were ready for discharge within 48 hours. The assessment of patients' satisfaction, with the caring they experienced from nurses, examines the nurse-patient relationship and determines essential dimensions critical to caring.

While the terms nursing and caring in the literature appear somewhat married, caring has been identified as the heart of nursing. However, research from the nurses' and patient's perspective has presented a real dichotomy. Patients rated the technical aspects of nursing as important, and nurses' value and identify psychosocial skills as important caring behaviors.

A study by Larsson, Peterson, Lampic, von Essen and Sjoden (1998) studied patient (N=53) and nurse (N=53) measurement of important caring behaviors using the CARE-Q instrument. This research identified ratings of patient levels of anxiety and depression to perceived behaviors of comforting and caring. Patient and staff ratings were negatively correlated.

A study by Morrison (1989) identifies the significance of some nurses' self-perceptions of caring. Using a Repertory Grid Technique, the nurses were asked to consider the elements of "ideal self as carer" on a seven-point rating scale. All nurses (N=25), perceived a shortfall in their own performance and satisfaction with care giving. Nurses' set very high standards and their expectations related to caring were not realistic in the practice setting.

Mangold (1991) offers a comparative study of professional nurses' (N=30) and nursing students' (N=30) perceptions of effective caring behaviors. Results indicate an agreement between the students and the nurses regarding caring behaviors: listening to the patient was considered the most important caring behavior.

The Professional Caring Behavior Instrument was utilized by Harrison (1991). Caring perceptions of Hospice patient families (N=14) and nurses (N=14) were studied. The perceptions were similar for both groups. The caring nurse does not treat patients like objects, provides support to families, removes soiled linen promptly, and attends to the patient's needs when they are upset. On the other hand, respecting spiritual needs of the family emerged as significantly more important for the nurses than for the family.

Dyson (1996) studied nurses' (N=9) conceptualizations of caring attitudes and behaviors. A Repertory Grid Technique was used to complete this study. The findings

support previous studies, which identify a humanistic and psychosocial emphasis: caring is a combination of what the nurse does and what the nurse is like as a person. Common themes included: being considerate, giving of self, being honest, and sincere.

Wolf, Riviello Giardino, Osborne and Stahley Ambrose (1994) conducted a study of patients' (N=263) and nurses' (N=278) responses to the dimensions of caring, using the Caring Behaviors Inventory (CBI). The responses were combined. The five dimensions included: respect, assurance of human presence, positive connectedness, knowledge, skill, and attentiveness to other's experience. Wolf et al (1994) concluded that these five dimensions fit with Watson's (1988) theory that nurse caring exists in consciousness and occurs with time. The question of how nurses can transcend a caring presence when they are working in environments with time constraints remains to be addressed.

An extensive study by Watson and Lea (1997) utilized the Caring Dimensions Inventory (CDI) to validate the elusive phenomenon of caring vis a via a reliable, quantitative measure. A large sample of nurses and nursing students (n=1430) were obtained. They rated aspects of nursing practice utilizing a Likert scale. Promoting self-care, monitoring and following through, comforting, trusting, and answering questions were perceived as important by the study cohort. However, the sample was not random, therefore, it is not possible to generalize the findings to other groups. As well, the study did not identify the areas of practice in nursing.

Marini (1999) applied the Caring Behavior Assessment (CBA) instrument to interview a convenience sample (N=21) of geriatric residents, in an attempt to determine older adults' perceptions of important indicators of caring demonstrated by the nurse. The

results revealed that the most important behavior was the nurse's technical competency in meeting physical needs. Although the sample size was small, the results are consistent with other studies (Cronin &Harrison, 1988; Huggins, Grady, & Kohut, 1993; and Parsons, Kee, & Gray, 1993).

Thus, the concept of caring has been studied utilizing multiple caring assessment tools. They include numerous other caring measurements. These caring instruments are based on varying definitions of caring. The lack of consensus in nursing regarding the definition of caring will continue to challenge nurse researchers. Utilization of the findings from qualitative caring studies may assist to conceptualize caring, particularly from the perspective of the nurse: the giver of care.

Nursing has changed dramatically in the past 20 years. Several of the scales that have been developed assist to determine quality assurance in institutions, by comparing patient and nurse perceptions of predetermined caring behaviors. Results indicate inconsistency between various studies. The perception of the nurse is imperative. Quantitative research may not lend itself to the enhancement of the caring concept, as pre-existing behaviors are rated, rather than listening to stories from the experience of the nurse. It remains an open question whether caring can be tangible or that the perception of caring has changed in the past 20 years. If the practice of nursing has changed over the past two decades, what is the effect on the nurses' perception of important caring behaviors? Caring may no longer mean the ability to bring the patient a cup of coffee and a newspaper, as was stated on several of the scales that have been used.

Qualitative Measurement of Caring

The focus on caring has been directed toward quantitative methodology. Qualitative research on caring has been limited, however, qualitative studies are appearing with increased frequency in nursing research, despite criticism that they fail to meet scientific methodological rigor. Qualitative research invites human understanding through human experiences, capturing the essences of experiences through individual narration.

Phenomenology, an inductive, descriptive, research method has been utilized in qualitative studies of caring. A study by Drew (1986) explored the patient's (N=35) experience with caregivers (i.e. nurses, physicians, health care aids). The study arose out of discontent from patients and families with the quality of human interaction found in the health care system. The findings focused on care-giving expressions that patients felt were important, but were lacking. The results suggest a more humanistic approach be heightened. The essence of health care remains with the relationship between the giver and the receiver of care. While science and technology have advanced, the humanization of care has not shown the same progress. Nurses may not be intentionally ignoring patients, however, they may not have the time to provide personalized care: care that meets the patients' needs and completes the nurses' feelings of a job well done.

Forrest (1989) investigated the phenomenon of caring with hospital staff nurses (N=17), describing their subjective experiences of caring. In the analysis theme clusters and categories arose. Two broad classifications: what is caring and what affects caring, emerged from the data. Nurses identified that caring arises from a deep and genuine interest in people. Caring involvement, caring interactions, giving of one-self, focusing

on the patient, coping, and providing comfort and support were identified as major categories from the data analyzed. Forrest (1989) describes the implications for nursing education, research, and practice, encouraging other nurse researchers to replicate his study and explore caring through the lived experience of the nurse.

Chipman (1991) attempted to clarify the meaning and place of caring in nursing practice as perceived by second-year diploma nursing students (N=26), to assist her in revising the curriculum. The students were asked to describe critical incidents in which they observed caring and non-caring behaviors in clinical practice. Caring was described by the students in humanistic terms, emerging in three categories: giving of one-self, meeting patients needs in a timely fashion, and comfort measures for patients and their families. Non-caring behaviors were the opposite of caring. The presence of the nurse as giving oneself and sharing oneself was important. The students identified humanistic behaviors rather than technical aspects of nursing to be salient caring behaviors.

A study by Clarke and Wheeler (1992) focused on the meaning of caring, based on the experiences of practicing staff nurses (N=6). Phenomenology, which was chosen as the methodology, acknowledges the meaning of an experience. Four major categories emerged from the data: being supportive, communicating, pressure (i.e. physical and emotional tiredness), and caring ability. Caring means a certain connection with patients by listening to them and communicating concern, making the patient feel understood and meeting their needs. Clarke and Wheeler (1992) challenge nurse researchers to enhance the understanding and meaning of caring through the perspectives of nurses. This study highlights the importance of caring from the perspective of the nurse.

A study by Milne and McWilliam (1996) identifies the consideration of "caring time" as a nursing resource. The purpose of this investigation was to explore the meaning of nursing as a resource. The study included patients (N=6) and health care professionals (N=14), including nurses, nurse managers, and physicians in an acute care hospital: all individuals directly responsible for the patients care. Nursing resource time was depicted as caring time and was understood as spending time with the patients. Being with, doing to/doing for, the patient was emphasized as integral. Sharing and connecting with patients determined the elements of caring time. All participants identified that skill oriented nursing competencies and activities were considered quantifiable work in nursing time.

Nelms (1996) offers a hermeneutical analysis of living a caring presence in nursing practice. Nelms (1996) attempted to clarify common meanings of caring from the perspective of nurses (N=5). Although the sample size is small, rich narratives from the participants were analyzed and interpreted. Themes included: timelessness and spacelessness of caring, creating home, and the call to care. In the stories described by the nurses, they truly embraced themselves as caring beings.

In a study utilizing grounded theory, Williams (1998) examined caring from the perspective of the nurse. Nurses (N=10) from four surgical units were interviewed. Exploration and description of the delivery of quality nursing care, identifying factors that enhanced or inhibited care, was the focus. Quality of nursing care in this study was assessed in terms of meeting patient's needs. The nurses emphasized the importance of meeting patients' psychosocial needs rather than their physical needs.

Idvall and Rooke (1998) conducted focus group interviews (N=20) seeking out nurses' perceptions of important aspects of caring on surgical wards. The participants

perceived that the new practice environment impacted on their delivery of quality care. However, in this study, only positive impacts of caring were discussed, eliminating negative factors that may hinder quality care.

Bertero (1999) completed a study identifying the meaning of caring through narratives utilizing phenomenology. The nurses (N=10) were selected from specialty areas including hematology, oncology, and respiratory medical units. The nurses were asked to describe a situation in which they had been able to supply good caring and narrate a situation where they were unable to provide what they felt was good care. Analysis of data revealed several themes. The most important theme interpreted was developing and maintaining a helping-trusting relationship. Bertero (1999) maintains that it is in caring that the nurse and the patient connect with one another, and thus experiencing growth and fulfillment. The author concludes that if nurses are allowed to develop and practice with this perspective, they will feel fulfilled and satisfied with their profession.

Summary

A review of quantitative and qualitative research literature about the concept of caring has been delineated. Quantitative research is vast, utilizing rated pre-determined caring behavior criteria through a variety of measurement tools. The settings for this research were in specialty areas, such as oncology, psychiatry, the hospice environment, and geriatrics. Patients, nursing students, and nurses have participated in these studies, and some of the studies have compared these groups. Only one quantitative study utilized medical-surgical nurses. Acute care areas have been relatively neglected in caring research. As the majority of patients are cared for on medical-surgical wards in hospitals,

this presents a vast gap in the literature. The question of whether the "conveyor belt" approach on many acute care surgical units limits the time to care, or minimizes how nurses understand the meaning of care in their practice remains unanswered. Although the term caring has been so overused in nursing that its invisible presence is taken for granted, the caring experience of the acute care surgical nurse has not been explored.

A dearth of qualitative studies describing the experience of caring from the perspective of the nurse has been discussed. Within current economic restraints, time constraints, nursing shortages, advancing nursing technology, and surgical technology, further research is required to ensure that nurses find innovative strategies to ensure that the caring experience is continued, and that caring remains central to the nursing profession.

CHAPTER THREE: THE RESEARCH DESIGN

Introduction

This chapter identifies the research method, beginning with an overview of the phenomenological approach used in the study. An explanation of the research plan including the sample, demographic information, participant selection, study setting, data collection methods, the interview process, data analysis, and the necessary steps that were taken to verify the research findings. The chapter will conclude with a discussion of ethical considerations.

Phenomenology: Philosophy, Approach, and Method

Phenomenology attempts to study and understand the human experience as it is lived. Phenomenology is a philosophy, an approach, and a method. Omery (1983) states that if phenomenology is individualistic and congruent with nursing's metaparadigm – person, health, nursing, and environment, then phenomenology may be considered a valuable philosophy for informing nursing practice.

Phenomenology, a philosophy, approach, and a method, is just one way of understanding nursing practice. Polifroni and Welch (1999) explain that it is a philosophy, or a reflective discipline, of the lived experience as it attempts to understand how meaning is derived through the human experience. This philosophy guides the researcher to understand thoughts and emotions, in an attempt to understand what is inside the person and what the person finds meaningful in their life. Phenomenology is viewed as a science in which we come to know metaphysical concepts of the mind; expressing these concepts, such as caring, in meaningful ways.

The phenomenological approach is individualistic in nature as it focuses on a person's unique experience of the phenomenon under investigation. In nursing practice and research, the individual is the essence. Phenomenology is often referred to as the study of "essences." As caring is coined the essence of nursing, then phenomenology may be the perfect "fit" as research method. Omery's (1983) classic article discussing phenomenology, as a method for nursing research, explains that the method is really the approach. The method is approaching the phenomenon with no pre-conceived expectations, proceeding to define the limits of the experience and then exploring the meaning of that experience by the participants. Describing the lived experience of people and the documentation of that experience should be done in such a way that is true to the lives of the people described.

Annells (1999) offers a current interpretation of phenomenology as an interpretive qualitative form. Phenomenologists use various methods to describe an experience interpreted into words by participants. The aim of the research is to abstract the experience into themes, commonalties, and uniqueness. The philosophical base of the lived experience is considered to be more important that the methodological steps.

The goal of phenomenological research is to understand the human experience from the individual's perspective. Phenomenology generates hypotheses as it seeks to answer "what" in order to reveal the experience through descriptive research (Knaack, 1984). "The concept of caring can be rediscovered by exploring: What does this mean to you?" (Sorrell & Redmond, 1995).

Phenomenology: Relevance to Nursing Practice

Qualitative methods, such as phenomenology, offer an alternative approach to the objectivity of quantitative inquiry. A growing number of nursing researchers are engaging in qualitative methodology to investigate phenomena of interest, as it relates to their discipline. In the real world of nursing practice, scientific, quantitative measure can be problematic. Given, that nursing occurs in "real world practice," the research method chosen must be able to generate meaning from nurses. Quantitative methods of objectivity may not portray life experiences and meaning from the expressions of nurses.

Lawler (1999) explains that phenomenology is an interpretive, or descriptive research mode, that does not seek generalizability, but rather enhance nursing's knowledge base. Van Manen (1997) states that the tendency to generalize may prevent the development of understanding the uniqueness of the human experience. The insight derived from phenomenology related to practice is important for nursing. Nursing needs to draw on a variety of ways of knowing to reflect the uniqueness of the profession. To understand life as humans live it and find meaning in it is the focus of phenomenology.

Sorrell and Redmond (1995) propose that phenomenological interviews focus on the understanding of meanings, with rich descriptions that shape the context of the experience. Listening and gaining insight into the narrative story is an important source of data rooted in the phenomenological movement. Nurses are attuned to active listening and probing questions. Asking "what" or "how" about a phenomenon, such as caring, is something nurses do tacitly.

Jasper (1994) explains that recognizing experiences that are unique to the individual, but which might have common characteristics, has significant meaning in

regards to nursing care, especially in times when current economics may lower standards of care. Phenomenology provides nursing with a method that focuses on the individual experience, which can enhance high-quality nursing care. Researchers must embrace and expand various methods that fit the research question. Phenomenology is an ideal way of describing the nature of elusive concepts, such as caring. The phenomenological method or guide, which was applied to this study, will be discussed later in this chapter.

Methodology

Data Analysis

In phenomenological research, data analysis is concurrent and ongoing during the data collection process. Data analysis followed as soon as the interview was transcribed. The researcher becomes immersed in the data to preserve the uniqueness of each participant's lived experience, in an attempt to understand the phenomenon under investigation (Streubert & Carpenter, 1999). Listening to the participants' narratives, reading and re-reading the transcripts are important. Significant statements were recorded, indexed, and filed for future categorizing. The goal is to capture the essential relationships between statements and identify central connected themes (Streubert & Carpenter, 1999).

Hermeneutic Phenomenology

The philosophy of phenomenology is a human science, which studies individuals. Phenomenology is interested in what is essentially unique. Hermeneutics and phenomenology are complimentary human science approaches that are deeply rooted in philosophy. Hermeneutic phenomenology attempts to describe both terms of this methodology: it is descriptive (phenomenological) and interpretive (hermeneutic).

Roberston-Malt (1999) states that the value of combining hermeneutical analysis with phenomenology is in the methods ability to encourage the researcher to move beyond superficial explanation and experience the participant's stories. The researcher must be able to describe the experience through language, in order to make visible what is involved in the experience.

This study was guided by van Manen's (1997) hermeneutic phenomenological research, which combines the descriptive and interpretative features into the method. Van Manen (1997) claims that "description" includes both interpretative (hermeneutic) and descriptive (phenomenological) elements and the terms are often employed interchangeably. It is important to remember that phenomenological descriptions are aimed at elucidating the lived experience, and that the meaning of these experiences is unveiled.

Van Manen's Guide to Human Science Research

Van Manen's (1997) process of phenomenological reflection and analysis, including six inter-related research activities, were utilized for this study. These six methodological activities will be discussed later. First, I will explain why I chose this method and the relevancy of the method to the study.

Van Manen's (1997) work is relevant to nursing and to researching the lived experience. Phenomenological sensitivity of the lived experience is the focus of the research approach outlined by van Manen (1997). Van Manen (1997) states that "to do research, is always to question the way we experience the world, to want to know the world in which we live as human beings" (p. 5). The author states that "research is a caring act: we want to know that which is most essential to being" (p.5).

Phenomenology asks for the very nature of a phenomenon: "What are the expressions of caring through the eyes, thoughts, emotions, and reflections of nurses in contemporary surgical nursing?" It is an attempt to uncover and describe the internal meaning of structures; of the lived experience. "The language of the description of essences shows us the significance of the experience in a fuller and deeper manner " (van Manen, 1997, p.10). This method fits with capturing the essence of caring from the perspective of the nurse. Benner (1994) explains that van Manen's (1997) method is a practical approach to phenomenology that blends Husserlian and Heideggerian philosophy. She continues that van Manen's (1997) approach provides salient guidelines, especially for the beginning researcher.

Van Manen: Methodological Structure

Van Manen (1997) explains six activities to assist with this methodology. They are described as follows: (1) turning to the nature of the lived experience; (2) investigating the experience as we live it; (3) reflecting on essential themes; (4) a description of the phenomenon through the art of writing and rewriting; (5) maintaining a strong and oriented pedagogical relation to the phenomenon, and (6) balancing the research context by considering parts and whole.

Turning to the Nature of the Lived Experience. A project of phenomenological inquiry is driven by commitment from the researcher toward the study. The research project must be of interest to the researcher. There should be deep questioning of something that is meaningful. Although phenomenology is fullness of thinking and embodiment of the experience, it is one interpretation of human experience through reflective writing.

Investigating the Experience as We Live It. Phenomenological research requires the researcher to actively explore the lived experience in all aspects and to understand the nature of the experience. The inquirer must seek to understand this experience from those who live it as an intimate part of " being in the world." This means that the researcher is in a constant state of striving to understand and attach meaning to our own (and others) numerous ways of being (Robertson-Malt, 1999).

Reflecting on Essential Themes. Phenomenological research makes a distinction between appearance and essence. "This refers to the difference between the things of our experience and that which grounds the things of our experience" (van Manen, 1997, p.32). This means that concepts, which tend to be obscure, but are part of life, are grasped, or reflected upon. Van Manen (1997) states that themes are not generalizations, but webs of our experiences spun into a whole meaning.

The Art of Writing and Rewriting. Van Manen (1997) describes this activity as "bringing speech to something." Human science research is a form of writing. Writing allows others the ability to see or to show something about an experience. Van Manen (1997) describes several steps that were applied during data analysis, including isolating themes and revisiting these themes.

Maintaining a Strong and Oriented Relation. Phenomenological research demands that the researcher remains strong to the fundamental question. It was easy to become "side-tracked" and wander to pre-conceived opinions. Written text needs to be thick, rich, and deep in order to describe experiences that are unique. This was accomplished by sifting through and recognizing essential from non-essential themes during the analysis.

Balancing the Research Context by Considering Parts and Whole. Van Manen (1997) attempts to clarify the importance of taking a step back and looking at the total context of the research findings, while considering how each part contributes to the total. How do the findings contribute to the question asked? The analysis process was completed when the researcher could no longer uncover new themes.

In summary, van Manen (1997) cautions potential phenomenologists. The author emphasizes that the six research activities should not be approached as a mechanistic or "cookbook" method toward phenomenology. They are not organized steps or a "how to" approach. "The most critical aspects of the research process is in the thoughtfulness and writing talents of the human science researcher" (van Manen, 1997, p.34).

I will use the term method, or guide, to conduct human science research. Van Manen (1997) would likely not agree, as "method" refers to a definitive set of procedures. The van Manen (1997) approach helped to guide this research, utilizing the above six inter-related research activities to assist in data analysis and the development of themes extracted from the findings.

Criterion of Rigor

It appears in the literature that qualitative investigators have attempted to defend phenomenology, as quantitative measures have adopted clear-cut methods that ensure reliability, validity, and scientific rigor. The issue of rigor in qualitative research is important to the practice of good science. Qualitative research is valid and trustworthy when it accurately represents the experience of the study participants (Streubert & Carpenter, 1999). Qualitative researchers have assumed a variety of terms that parallel quantitative measures. Struebert and Carpenter (1999) discuss four terms that support

rigor: credibility, dependability, confirmability, and transferability. Rigor will be addressed to ensure that the study participants' were accurately described. I will explain the operational techniques in relation to van Manen's (1997) approach.

Credibility

According to Struebert and Carpenter (1999), credibility includes activities that demonstrate that credible findings will be produced. Prolonged engagement with the subject matter is important. Van Manen (1997) proposes that deep immersion in the data, or dwelling, requires the researcher to commit fully to understanding what the data say. Van Manen (1997) encourages maintaining a strong and oriented relation or staying focused. In my study, data collection and data analysis were concurrent, allowing the researcher to actively engage in performing data analysis.

Dependability

Similar to validity in quantitative research, qualitative research addresses the dependability of the results. Van Manen (1997) attempts to clarify the importance of looking at the context of the findings, considering how each part contributes to the total findings, and how the findings contribute to the questions asked.

Confirmability

The objective of confirmability is to illustrate, as clearly as possible, the findings and thought processes that led to the formulated meanings and conclusions of the researcher. Van Manen (1997) outlines the art of writing and rewriting, which allows others the ability to see or to show something about and experience. Writing helps to measure thoughtfulness.

Transferability

Transferability or "fittingness" refers to the probability that the findings of the study have meaning to others in similar situations. The reader, the participants, and potential users of the findings need to recognize the experience. The intention is to be able to apply the research within the reader's own frame of reference. It is the responsibility of the researcher to provide thick, rich, and deep written text in order to describe experiences. Van Manen (1997) summarizes that phenomenological human science does not provide explanations, but attempts to recover reflectively a deep sense of the experience, in order to share everyday real life concerns within a particular group, such as nurses.

Trustworthiness (Validity) and Authenticity of Data

According to Streubert and Carpenter (1999), bracketing is the cognitive process of putting aside one's own beliefs, not making judgments and remaining open to the data as it is revealed by the participants. In phenomenology, this is carried out by an attempt from the researcher to make a conscious endeavour to lay aside pre-conceptions about the phenomenon under study. My assumptions have been outlined in Chapter One. I kept a reflective journal, expressing my own thoughts and experiences during the interview process. I have viewed each participant as an expert informant.

During the interview process, requesting both positive and negative experiences of the phenomenon under investigation is helpful in establishing authenticity and trustworthiness of the data (Streubert & Carpenter, 1999).

Validity of the findings of phenomenological research depends on the ability to convince the reader that its findings are accurate, which may hinge upon the skill,

competency, and integrity of the researcher as instrument (Halldorsdottir, 1996). Van Manen (1997) refers to this as the "phenomenological nod." The researcher exposes an aspect of daily life so it can be understood and recognized by those who share similar experiences. Van Manen (1997) emphasizes that writing allows others the ability to see or show something about an experience. The writing of the researcher is the key to the success of the project.

Once the data were analyzed, and the findings and the discussion sections were examined by the committee members, I mailed each participant a summary of my research along with a thank you letter and an invitation to attend the Thesis Oral Defense (see Appendix I, p. 139). This provided each participant an opportunity to validate the themes and essential structures of the findings with me.

Research Plan

This section will outline the method that was used for this study. The selection of participants, setting, data collection methods, demographic information, interview guide, data analysis, and ethical considerations will be discussed.

The Sample

A volunteer, purposive sample of nurses (N=10) who worked on surgical units (i.e. surgical nurses) was the focus of this study. Qualitative studies use small non-random samples. Polit and Hungler (1999) discuss that purposive or judgmental sampling is subjective and does not provide an objective method for assessment. However, the authors are primarily concerned with quantitative methodology, which does not capture the rich experiences of the participants. Purposive sampling can be used to an advantage for qualitative researchers. This study required a sample of experienced surgical nurses.

The experience and perspective of the nurse was the key to this study, therefore, this method was advantageous to the research problem and is considered acceptable. Polit and Hungler (1999) explain that in qualitative studies, the key is to extract the greatest possible information from the samples.

Participant Inclusion Criteria

The criteria of selection developed for this research method was as follows. Participants considered suitable to participate in the study met the following criteria:

1. Minimum of five years experience in nursing
2. At least one year experience in surgical nursing
3. Must provide direct patient care
4. Must have responded to "Invitation to Participate in a Research Study" (see Appendix A, p. 131)

Participants in this study had at least five years experience in nursing and at least one year of experience working in surgical nursing. Nurses who have worked or are currently working in the surgical arena were interviewed, as the study considered caring experiences of front line nurses in contemporary surgical practice. The participants responded to the research invitation and signed a consent form (see Appendix B, p. 132) for permission to be interviewed.

Recruitment

Permission was accessed through a tertiary institution, which operates a variety of acute care surgical units and an ambulatory surgical center. After permission was obtained from the hospital, (see Appendix G, p. 137) and the Ethics Review Committee (see Appendix H, p. 138), participants were sought through posters (see Appendix C, p.

133), and consulting with unit managers from surgical units and day surgery (see Appendix D, p. 134). A written description of the study and an invitation to participate in the project was provided on the various units to assist in screening the specific participants. Participants were asked to identify themselves by submitting the response form that consists of a tear-off portion of the Invitation to Participate in a Research Study (see Appendix A, p. 131). Participants mailed the tear-off portion (including participant name and home phone number) of the form to me via the Inter-Departmental mail system at the University of Manitoba using a self-addressed envelope, which was provided. When the response was obtained from the participant, I made telephone contact. The interview was set up at the convenience of the participant. One interview occurred with each participant.

The Setting

Interviews took place in locations that were private, comfortable, relaxed, and convenient. Since many nurses work a variety of shifts, interviews were conducted at a time that was suitable to the participants. The hospital setting or unit itself was not conducive to the interview, as it was not considered private. Therefore, the participants were asked to consider their home, my home, or a mutual place of meeting.

Data Collection Methods

Demographic Information

Demographic information, such as years of experience in surgery, years of experience in nursing, age, and gender were acquired from each participant at the beginning of the interview (see Appendix E, p. 135). A summary of this information is included in the thesis to provide a synopsis of the years of experience, current nursing

position, gender, and age of the participants in the study sample (see Table II, p, 52). Demographic data was also related to the findings from the data and is also examined in the final chapter of this study.

Interview Procedure and Data Treatment

I arranged the interview date, time, and location with each participant. The interview followed a semi-structured guide (see Appendix F, p. 136). Semi-structured interviews tend to be conversational and interactive in nature, which is conducive to qualitative research. Van Manen (1997) emphasizes the need for the researcher to be oriented to the question, in order to avoid being carried away from the quest for the meaning of caring. Van Manen (1997) continues that it is imperative to ask what the experience is like and to be able to stay close to the experienced as it is lived. "A personal life story is achieved by asking the individual to recall and share specific instances and events, exploring the experience to the fullest" (van Manen, 1997, p. 67). Respondents reflected their stories in a narrative fashion, guided by the questions and probes of the researcher. The interview questions encouraged the participants to define the important dimensions of the phenomenon (Polit & Hungler, 1999). Probes elicit more useful information from the participant than was given during the first reply. A list of probes that were used are listed in the interview guide (see Appendix F, p. 136). Van Manen (1997) recommends that although ready-made questions may be impossible, a semi-structured guide will assist to begin the interview and keep the researcher focused to the question.

The interviews were tape-recorded. The body language and emotional responses of the participants were noted. I recorded field notes in a personal journal after each

interview. Polit and Hungler (1999) suggest that field notes may help the researcher begin synthesizing and understanding the data. A framework suggested by Polit and Hungler (1999) consists of categories of field notes: observational, theoretical, methodological, and personal. I utilized this guide to help organize my thoughts. Taped interviews were transcribed verbatim. The interviews lasted approximately one hour, or longer when participant desired. After the interview, it was anticipated that participants may have had additional thoughts that they would like to share. I ensured that the participants had my phone numbers, if they wished to add any reflections to the interview once they were completed. I listened to the tapes and read the transcription to ensure accuracy. This helped me to immerse and familiarize myself with the data.

Ethical Considerations

The nature of phenomenological research results in several ethical considerations that need to be discussed. The following elements were crucial to the success of this research project.

Informed Consent/Voluntary Participation

Informed consent was obtained from each participant. They were asked to read and sign a consent form (see Appendix B, p. 132). The consent form outlines that nurses voluntarily decided if they want to participate and that they could terminate their involvement at any time during the research study. To avoid coercion by the researcher, consent forms and self-addressed envelopes were provided for the participants. Participants signed their name and included their home phone number on the form (see Appendix A, p. 131).

Maintenance of Confidentiality

Each participant was assigned a code identification number in order to identify the tapes and transcripts. The code number is separate from the transcripts, demographic information, and the consent forms. This information is stored in a safe locked location. Participants were given pseudonyms to ensure confidentiality. Subsequent analysis and any publication of the research data will not identify the hospital utilized. None of the participants will be identified.

Access to Gathered Data

Demographic has been stored separate with a code number and accessible to myself only. A promise of confidentiality was given to all those who participated in the study. Access to the transcripts, were limited to me, the transcriptionist, my thesis chairperson, and the internal and external members of my committee. This was clearly stated in the consent form.

Storage of Data

Consent forms, transcribed interviews, tapes, written notes, demographic information, and my journal, are kept securely in a separate location. This material will be stored for a period of 10 years, at which time all elements of this research will be shredded and destroyed as confidential waste.

Recording of Data

The audio taped recordings were transcribed verbatim by a transcriptionist. The importance of confidentiality was emphasized to the typist. Each interview was entered as a file using a Word 97 Program and also on a computer disk using a pseudonym name

and number. Hand written notes, which were based on observations after each interview, are safely stored as well.

Plans for Future Use of Data

Findings will be presented during the thesis oral defense, research conferences, workshops, grand rounds, and invitations to research seminar series. Submissions to nursing journals will be considered in the future.

Potential Benefits to Participants

Potential benefits to the participants are unknown at this time. The opportunity for these nurses to reflect on expressions of caring in nursing practice may assist them to identify the changes that have occurred in contemporary practice. This may assist participants to understand where they have been and directions for the future. This research opportunity will help to expand and enhance the knowledge base of surgical nursing today. The knowledge from this project is central to the everyday concerns of nurses working in all areas of acute care practice.

Burdens/Cost to Participants

The time commitment for the nurses participating was the only identified burden. The participants were informed that the interview process would be approximately one hour, and it was extended only if the participant agreed. Every effort was made to accommodate potential participants to ensure respect, privacy, convenience, and comfort.

Risk to Participants

There were no identified major emotional risks or stressors involved in this study. The nurses were interviewed and asked to share caring experiences. Given the nature of the research, some emotions did occur. The participants were assured that their stories

were not being told to be judged, but rather to be used as information to provide a better understanding of the phenomenon under study. The informed consent form (see Appendix B, p. 132) clearly stated that the participant could stop the interview at any time, or withdraw from voluntary participation in the study at their discretion. No coercion was used during the interviews.

Summary

This chapter discussed the research plan. The rationale for the phenomenological methodology and the relevancy to nursing and to the research project were also explained. Discussion of the participant criteria, sample, setting, data collection methods, data analysis, and approach was provided. The establishment of rigor, trustworthiness, and authenticity in the study was discussed. Ethical and moral aspects of qualitative research are important. The considerations presented here followed ethical requirements associated with qualitative research in nursing.

CHAPTER FOUR: FINDINGS

Introduction

This chapter presents the findings from the study, which includes a description of the sample, and a report of the findings that have emerged from the data. Pseudonyms have been given to each participant in order to protect their identity.

The Sample

This section describes the sample, which consisted of 10 participants. The interview setting, gender, age, educational background, and nursing practice experience of the participants have been summarized (see Table II, p.52).

Sample Attributes

Interview Setting

As identified in Chapter Three, each participant chose a convenient location for the interview. Five nurses chose to be interviewed in their own home; two were interviewed in an office; one chose a restaurant, one met me at a church, and one participant was interviewed in my home. Each interview lasted approximately one to one and a one-half hours. I attempted to create a comfortable milieu for the participants to give voice to their experiences in an open and free-flowing manner, whilst responding to the posed questions (see Appendix, F p.136). All participants were invited to contact me at anytime after the interview, if they felt that they needed to add further thoughts to our discussion, or if they wished to omit some portion or part thereof.

Gender and Age

All 10 participants in the study were women. They were asked to respond to a pre-determined age category on the demographic form (see Appendix E, p.135). Participant ages varied from 25 to older than 45 years of age. Three of the nurses were less than 35 years. There were six nurses who were between 35 and 45 years, and one was older than 45 years of age.

Education

Eight nurses were diploma prepared registered nurses. Four of the eight are enrolled in an undergraduate baccalaureate program. One nurse has completed a Masters Degree in nursing, while another is currently enrolled in the Master of Nursing Program.

Years in Nursing Practice

The range of the number of years in nursing practice varied from five years to 22 years. Only two participants had less than 10 years of nursing experience. There were five nurses who had more than 10 years, but less than 20 years experience and three participants who had been a nurse for 20 or more. As a group, a total of 148 years in nursing practice had been achieved. Therefore, the average number of years practicing as a nurse was 14.8 years.

Years in Surgical Nursing Practice

All participants met the criteria of a minimum of five years experience in nursing and at least one year of experience in surgical nursing practice (see Appendix A, p.131). Five nurses had 10 or less years practicing on an acute care surgical unit; four participants had more than 10 years but less than 20 years in surgery, and one participant

had 20 years of experience in surgery. The total number of years of acute care surgical practice was 103. 5 years, with the average number being 10.35 years of experience.

Practice Setting

Participants had practiced in a variety of surgical settings. The medley of clinical areas are outlined in Table II (p.52). Seven nurses had worked or are currently working, in a surgical float pool position. Four of these seven nurses, who had previously floated, recently found permanent positions on surgical units. These four nurses are between the ages of 35 to 45 years. Three of these nurses have secured positions on a burn unit, while the other nurse works on a combined acute care and rehabilitation neurology unit. One of the seven nurses continues to work in the surgical float pool. This particular nurse had the most experience in the group of 10 participants (22 years) and the greatest number of years worked in surgery (20 years). Two of the nurses who continue to work in the surgical float pool are between the ages of 25 to 45 years. Of the remaining three nurses, one participant currently works on a cardiovascular unit as a nurse specialist, while another practices on an acute care neurology ward and the other has chosen to move to palliative care.

Expressions of Caring

Once I received the responses to the "Invitation to Participate in a Research Study" (see Appendix A, p.131), each participant was contacted by telephone to arrange the interview. The participants were asked to come to the interview prepared to voice what caring means to them in contemporary surgical practice and to reflect upon positive and negative experiences of caring in the surgical practice setting. Several anecdotes, expressions, and experiences were shared with the researcher from each of

the participants. As their stories unfolded during the interviews, the nurses articulated their experiences of caring during these personal reflective moments. At times their expressions and words were emotional. The interviews often proved cathartic, as the nurses reflected their thoughts, and past experiences and expressions of caring.

Summary

In summary, the sample was adequate for this particular approach to the research. The participants were able to share their expressions of caring, and for some it was the first opportunity to find an outlet of their professional philosophy, belief, value system, and concerns.

Table II – Sample Summary

*__Bold__ denotes recent practice position

Participant	Gender	Age	Education	No. of years in nursing	No. of years in surgery	Practice Setting
Nurse #1: Mary	F	25-35	Diploma	12	12	Surgical Float Pool
Nurse #2: Donna	F	35-45	Diploma	16	16	Surgical Float Pool
Nurse #3: Joanne	F	35-45	Diploma	20	10	Surgical Float Pool **Burn Unit**
Nurse #4: Marcia	F	35-45	Diploma	11	2 ½	Neurology
Nurse #5: June	F	35-45	Masters Degree	22	20	Surgical Float Pool
Nurse #: Jan	F	25-35	Diploma	7	7	Cardiovascular Surgery **Clinical Nurse Specialist**
Nurse #7: Sandra	F	25-35	Masters Program	5	3	Cardiovascular Surgery **Palliative Care**
Nurse #8: Terry	F	35-45	Diploma	17	5	Surgical Float Pool Trauma **Neurology Nursing Educator**
Nurse #9: Sally	F	45	Diploma	18	15	Surgical Float Pool **Burn Unit**
Nurse #10: Wendy	F	35-45	Diploma	20	13	Surgical Float Pool **Burn Unit**

An Exposition of Caring: Findings from the Data

Introduction

The semi-structured interview (see Appendix F, p.136) guided the participants to respond to five key questions, capturing their expressions and experiences of caring for acutely ill patients on surgical wards. Findings from the interviews explored data as experiential structures (themes) that make up the experience and reveal the meaning of caring from the nurse's perspective. Through phenomenological sensitive writing, these themes are presented here in.

Data Analysis

Human Science Research

Once the interviews were transcribed verbatim, thematic statements (essentials) were isolated as I utilized van Manen's (1997) selective reading or highlighting approach. I constantly asked myself: "What statements or phrase(s) seem particularly essential or revealing about the phenomenon or experience being described?" I read the text from the transcripts several times and I listened to each tape once. I made notes on the transcripts as I attempted to interpret and grasp the essential meaning of the experiences expressed by the participants. Each sentence or sentence cluster revealed expressions about the meaning of caring. The experiential structures emerged from the data to formulate meaningful themes, as I considered what was common and what was unique to each participant. I have organized the themes according to the relationship between the essences and the interview questions.

The Research Questions Revisited

The research questions that have been generated and sought include:

1. What are the expressions and experiences of caring from the surgical nurses' perspective?
2. What meaning do these caring experiences have for the nurses?
3. What made the caring experiences positive or negative?

Introduction of the Themes

To answer the research questions, I have organized the findings to best reflect the expressions of the participants. Four major categories, with the identified themes emerged: Nursing Care as Whole-Person Encounters, Caring: An Intrinsic Ideal, Lamentations and Loss: Caring in the New Millennium, and Accentuating Care: Ideal versus Reality. Each one of these categories evolved through the identification of the themes.

Nursing Care as Whole-Person Encounters

Body, Mind, and Spirit. Unanimously, all participants described caring in their surgical practice as the ability to care for the whole patient – attending to the body (the person), the mind (emotional needs), and the soul (spiritual needs). Physical, emotional and psychosocial needs, and understanding the patients wants and desires are part of caring. Caring is "looking after what they feel their needs are and what we see as their needs and trying to meld those two things together" (Participant #6: Line 90-92). Participants agreed that caring is more than psychomotor skills and interventions and that it encompasses the nurses' relationships with patients and their families. Nursing tasks are one type of intervention that assists to conceptualize caring into a deeper

broader concept – broader than tasks on a surgical unit. Caring is "80% social and 20% tasks" (Participant #3: Line 254). The challenge is to be able to balance physical, emotional, and spiritual care in the environment of contemporary practice. "It is like growing flowers, trying to put the right amount of everything in to make sure everything grows up strong. That it doesn't get too weedy - doesn't get to full" (Participant #3: Line 1031-1034).

Terry (Participant #8) expressed caring as a learned behavior that is based on personal, past life experiences:

> It's not an action. I think it is a feeling, but I think you can put your feelings into actions; to incorporate my feelings into actions so that I have the outcome that I want. Caring is a feeling. It's not an action or a description. It's a feeling. It's something that comes from within. That's something that I think that is learned. It's automatic (Line 7-14).

She expressed that caring is based on role modeling of others – from your own family and personal past experiences. Terry also discussed the lack of role models she had when she was in nursing school and that there was little to no opportunity to reflect on caring and the importance of caring in the nursing profession. She believes that caring is something that she has learned over time as she has grown professionally and personally. Terry discovered very gradually in her practice on a surgical ward, that nursing is the ability to care for the patient as a whole and that caring is an acquired feeling that goes beyond nursing tasks. Caring is not a concept that she thinks about everyday. Terry relates this to the fast pace on acute care surgical units.

Beyond Direct Patient Care: Nursing the Family. Participants agreed that caring is a broad term that includes care of the patient and the family. Caring includes attending to the family, even after the death of a patient – helping the family to move on. All of the participants' expressed the importance of going beyond direct patient care to encompass concerns, fears, and anxieties of the family. Offering the family hope and providing explanations was identified as significant aspects of caring. "You can't care for a person in the compact manner. You have to care for the whole family" (Participant #3: Line 57-59). Participants expressed the importance of nursing beyond the tasks and beyond direct patient care – to be able to consider the needs of the family. Family needs are part of the care of the patient. Once discharged home, it is often the family who may be responsible for the care of the patient. Participants described how important it is to teach the family and provide clear explanations. Nurses working in acute care understand the importance of not only making connections with the patient, but with the family as well. The family is often the key to the patient's successful recovery after surgical intervention.

Sandra (Participant #7) shared her experiences working simultaneously on both an acute care surgical unit and in a palliative care facility. She discussed the dichotomy that exists between the two different units. A major component of palliative care is working with families. In this environment, she has reaffirmed the importance of taking the time to teach the family and answer necessary questions and concerns. However, Sandra also expressed the difficulty dealing with families on a surgical unit. Due to time pressures, depending on the nurses assignment and the acuity level of the patients, there is often no time to spend with the families on busy surgical wards:

> I can get into spiritual issues with palliative patients because, first of all, you have primary nursing… same patient day in and day out" (Line 362-364). In surgical nursing, you usually care for the patient for the one shift, attending to their physical needs (Line 370-372). However, whether you are on a surgical or palliative unit, you are still talking to family. Family is important (Line 411-414).

Creating a Caring Environment. Participants remarked extensively on a variety of factors that are important in creating a caring environment. "Basic care is where you are able to really connect and talk to your patients and find out a lot of things that are important and that can make them feel like human beings and that they are important" (Participant #1: Line 508-511). A caring environment includes making the patient comfortable, being attuned to their needs, and ensuring the patient has a positive outcome and a "good" hospital experience. The nurses concern is for the wellbeing of the patient. The nurse creates a caring environment by setting priorities, listening to the patient, allowing choices, being an advocate, acknowledging effort, communicating by touching, hugging, maintaining eye contact, and possessing a gentle demeanor that transcends a genuine caring sense. The importance of the nurse patient relationship was strongly shared by all participants. Many nurses expressed that the development of trusting and intimate relationships is what assists them to keep coming back to their jobs; taking time to talk to the patient and ascertaining their perception of the experience – How do they feel? The caring environment acknowledges that individual patient concerns are important. The participants agreed that caring also means having a sense of humor! Being able to do the "little things" that are important to the patient also generates a caring sense.

Wendy (Participant #10) remarked that "a nurse has to remember that everything she does from the moment she walks onto the unit to the moment she leaves and that

beyond, impacts the patient. You directly affect someone's life" (Line 6-9). "If I could make one positive event happen in a patient's day - that's good. You have to remember that everything a nurse does is painful on a surgical unit" (Line 10-13). Although there are many uncomfortable tasks and procedures that patients endure before and after surgery, the participants attempt to ease the pain from these procedures and provide as much comfort as possible for the patient. The nurse is the health provider at the bedside and the nurse is the individual who can have either a very negative or positive impact on the patient's surgical experience. Participants were determined to try and make the experience as positive as possible.

Sally (Participant #9) reflected on her own experience as a patient before she became a nurse. She remembers the nurse taking the time to talk to her, asking her not only what her pain level was, but how was she feeling, what she was reading and what she was interested in. "She took interest in my surroundings and what was happening to me. She said to me 'you're still here.' I was wondering if you would still be here. The others bring the tray and plunk it down. The nurses were so distanced" (Line 640-647). This particular nurse made a connection by just taking the time to talk to her, observing her surroundings and asking her some basic questions. Sally believes that caring for patients is a sacred position and a privilege. She feels a deep sense of responsibility to provide care to the best of her ability on a fast paced surgical unit and in an environment where time does not always permit nurses to make those connections with their patients. Participants expressed that creating a caring environment in contemporary nursing included the ability to listen, to analyze, to prioritize, and to be able to act quickly.

Anticipatory Needs. Participants remarked on the ability of the nurse to anticipate the needs of the patient and the family, with the aid of keen observational skills. This experience is comparable to detective work – problem solving, fixing "things," while making the environment better for the patient. June (Participant #5) stated that "I just made the time to speak to the patient and find out why he was not feeling well – he was a little confused at the time. He had been in the hospital for 3 weeks and no one knew why. I took the extra time that morning to get a hold of the doctor to recommend pain control."

According to the participants, the ability to apply theory and knowledge to practice in order to look for trends in changes in the patient's condition, and be able to anticipate potential problems is imperative. Caring is anticipating and being attuned to the needs of the patient and the family. Joanne (Participant #3) expresses caring as "washing the patients back, phoning the family to bring in slippers, or doing a set of vital signs because the patient just does not look right and you are trying to get to the bottom of the problem" (Line 12-17).

A major aspect of surgical nursing is the preparation and teaching given to patients before they are discharged home. Patients are presently discharged earlier and are expected to care for wounds, dressings, and drains when they return home. There is a considerable amount of discharge teaching involved. Participants discussed caring in relation to anticipating the needs of the patient when they go home and assessing for potential problems that may occur once discharged from the hospital. Ensuring that the patient is actually well enough to go home and ascertaining whether they have the appropriate resources are priorities. Wendy (Participant #10) expressed that "You have a

moral obligation to look out for these people, anticipate what they need, send them home with what they need to care for themselves" (Line 493-497).

Advocating for the patient, who may need to stay in the hospital one more day post-operatively was also expressed by the nurses as important in their care. The participants extended caring beyond the hospital walls and doors. They exhibited genuine concern and worry about their patients once they are discharged home. Will the patient adhere to the discharge instructions? Will the family be available to care for them?

Teamwork. Participants talked about the importance of working as a team on a surgical unit and how this is an important aspect in the theme Nursing Care as Whole-Person Encounters. Participants discussed the need to develop trusting and working relationships not only with patients, but also with co-workers. An environment where colleagues work together, help each other, and convey a sense of caring toward each other is an important aspect of being able to give care to their patients. Terry (Participant #8) described an experience where a patient collapsed unexpectedly. The physiotherapist happened to be with the patient at the time of the fall. The physiotherapist was visibly upset and shaken up by the event. The nurse orchestrated the scenario, attending to the patient, the patient's wife, and the other members of the health care team, including the physiotherapist. "I wondered about the physiotherapist, how she really coped… I felt guilty about that… I worried about her… of course she was upset" (Line 2097-2105). Caring for co-workers and supporting one another was discussed as an essential component of caring. Working as a team not only includes caring for the patient and placing their best interests first, but caring for each other. Working in an environment

where the nurses knew they had support from coworkers and felt a sense of teamwork was described as essential in the theme Nursing Care as Whole-Person Encounters.

Summary

Nursing Care as Whole-Person Encounters consisted of five essential structures that were common in each interview: Body, Mind and Spirit, Beyond Direct Patient Care: Nursing the Family, Creating a Caring Environment, Anticipatory Needs, and Teamwork. Caring is a broad concept, however, the meaning of caring from the perspective of the participants has been revealed to assist in identifying what the experience of caring is really like.

Caring: An Intrinsic Ideal

Nursing Foresight. All participants shared experiences that they felt were positive caring experiences. The nurses shared situations in which they felt that they had provided quality, nursing care; care they felt satisfied with; care where they felt they had made a difference for the patient. Participants remarked that being able to anticipate patient needs, physically, emotionally, and spiritually, was considered a positive outcome for both the patient and the nurse. Donna (Participant #2) shared this story:

> The small little rewards of positive nursing is when you know you're right and someone actually acknowledges the fact that you've stopped something from happening. For example, someone is in fluid overload, or something and you pick up on it before the patient gets worse, and has to go upstairs to ICU (Line 919-924).

Participants identified the importance for the nurse to have good assessment skills as part of caring. Marcia (Participant #4) provided a discussion based on spiritual and religious aspects that she includes in her care. She was able to identify anxiety that the patient was experiencing the evening prior to surgery:

> I picked up cues that he was frightened… there was nothing in the Kardex about next of kin…I asked him if he was afraid to die? And he said yes. So I prayed with him that night before he went to bed. I prayed for him to have comfort and to not be afraid. The next morning, I was getting off my shift at 0730, but I stayed until, a little later, to get him ready, because they're going to come and pick him up at 0800. He grabbed my hand and said 'Wait, can you pray for me again?' And so I took his hand and I was praying with him, and I was praying for the doctors that God would lead their hands and give them wisdom (Line 478-500).

The opportunity to have the time to sit and talk to patient, and recognize when they are upset, can help to address and often alleviate patient anxiety prior to surgery. Participants discussed the skill of being intuitive, while exploring emotional and spiritual domains with the patient before and after surgery.

Timing and Availability of Resources. Many participants described situations that were considered a crisis initially, but turned out to be positive experience because of timing and the availability of resources. Positive experiences occurred when the nurses were able to spend time with the patient and family, answer questions, initiate discharge teaching, receive positive feedback from the patient, and coordinate complete care. Participants reflected on specific factors of time and availability and support from members of the health care team as being an important part in the overall outcome of the experience.

Mary (Participant #1) shared a positive narrative story that described how timing and supports enhanced the experience:

> I was caring for an off-service patient. Her oxygen saturation was low, and she was basically close to crashing. I had to contact the right people to attend to her physical needs and her family members were right there. I was looking after the physical aspect of the patient's care, but I also had the daughter crying in the corner. I had to deal with the physical needs immediately. I contacted the family physician and pastoral care. I think from start to finish, this was probably one of the best scenarios that I've ever been in as far as how smoothly it ran… this situation had come up spontaneously, and there were the right supports

> everywhere you looked.... we had a low census on the ward and that day we were well staffed...the doctors just happened to be available at the time (Line 105-113).

Mary's story described how support from the unit staff, including other nurses, assisted her to care for the remainder of her patient load. The health care assistants were available, physicians were accessible in a time of crisis, and the pastoral care services aided with the needs of the family. Her story describes a perfectly coordinated scenario where the team came together – the right time and the necessary resources.

June (Participant #5) describes a situation with a family member. Her experience tells the story of a young man who was mentally challenged. He lived with his mother, until she became ill, was hospitalized and died. The patient's condition quickly deteriorated and she was not expected to live:

> We actually ended up probably caring for the son more than we did for the patient...we were all crying when she died.....we called the pastor to come and sit with him for a while because we didn't have the time, although we took turns sitting with him. We didn't even go on coffee breaks because we stayed with him, because he was so emotional. Often we don't even have time to phone pastoral care....it probably wouldn't have been a positive experience if it had happened earlier in the shift. It was an evening shift and a lot of the work had been done and people were in bed. It was like a big family that night. So that's what I think nursing is supposed to be all about, and not what it is nowadays. We don't get enough time to do things like that. But in retrospect though it's exactly things like that that help me to keep me going in nursing. I don't want to quit the profession (Line 247-331).

Sandra (Participant #7) compared working on the unit versus a step-down unit, where nurses have a lower patient ratio:

> But in the step-down you found you could, you had more time typically to look after the patient.... I'm able to care for this person because, you know, I'm able to care for their every whim and need because I have one or two.... you really get to know their families.... I liked working in the step-down because of that, being able to care for the full person and the family (Line 712-721).

Timing and resources in this situation refers to the environment of a step-down unit, where the nurse-patient ratio is less. Sandra shared that in general, the step-down unit provided an increased opportunity for the nurse to care for the "whole patient."

Connecting. Connecting with the patient and the family was expressed by the participants as a positive caring experience. Timing, the length of time, and resource availability were identified as major factors that either supported, or impaired the ability to make a connection and develop a therapeutic relationship with the patient. Several nurses recalled experiences where patients did not have any family or the family had neglected the patient. Participants shared stories that expressed "being a surrogate family" for the patient or "adopting the patient as their family" when they had no one else. Many of these patients were long term patients on acute care surgical units. The nurses made a connection with the patient and became their family, in a special way. Often these patients continue to return to the units to visit the nurses; the caring connection has extended past the point of patient discharge.

Positive caring experiences included the privilege of spending the last hours or moments with a patient before death. Participants recounted how patients often shared intimate thoughts with them before their death. The participants felt honored to have shared the patient's last thoughts and words. Sally (Participant #9) described her experience:

> I grew to really love her… she was dying of ovarian cancer. We always used to chat and she was very religious…. she said she was not afraid to die. A few weeks later she took my hand and she said, 'I'm petrified, I'm terrified to die.' She thought that I would see that as a weakness in her. And I didn't. And I always remember her. For some reason she touched my heart (Line 104-128).

Wendy (Participant #10) discussed staying with one patient throughout her shift because she did not want the patient to die alone, as the family lived a considerable distance away and could not be present. Her other patients were stable, however, her colleagues were angry with her because they felt that she was not working as hard as they did. Wendy expressed this experience as positive, although, she did not receive support for her actions or decisions. She had made a connection with this patient and felt very strongly about her decision to be at the bedside. The family had not arrived to accompany the patient on their final journey. "I phoned the family. They wouldn't be in until the wee hours of the morning. I just didn't want her to die alone. I couldn't imagine" (Line 1409-1412). The devotion that nurses extend towards their patients is immeasurable. The sacredness of the nurse-patient relationship is a positive caring experience for the nurse. In this situation, the nurse was adamant that she had made a connection with the patient and felt very strongly about remaining by their side.

Advocating. Advocating for the patient was a topic reflected in every interview. Advocating was noted by participants as a positive caring experience; being able to advocate for patients when they are unable to do so for themselves. Advocating is placing the patients and their families' best interests first.

Sally (Participant #9) discussed a particular incident where she "went out on a limb" to advocate for a dying patient. The patient was an "off-service" medical patient placed on a surgical unit. The nurse spent time with the patient and the family and had developed a trust relationship. The patient's condition deteriorated, however, and the supervisor found a bed on a medical unit and ordered that the patient be moved. Sally felt comfortable expressing that since she had invested her time and energy caring for

the patient and the family, she would not allow the patient to be moved when death was imminent. She stated: " I think that it would be horrible for somebody who's dying, who know they're dying and uproot them to another place to die" (Line 1255-1257). Sally was willing to take the risk. She knew she had made the right decision for the patient and if that meant going against the policy, she was willing to do that. She was later reprimanded for her decision, but she felt she could justify what she had done. Sally stated that if this situation were to happen again, she would do the same thing. "That was a positive experience. It was a negative outcome, as the patient had died. I got in trouble, but it was positive because I knew I made the right decision" (Line 1214-1216). Caring, in this story, includes advocacy and the risks that nurses are willing to take in order to ensure that they feel satisfied that they have provided the best care possible and had acted in the best interest of the patient.

New Roles. Several of the participants shared positive caring experiences in relation to a recent change in position. These nurses had worked on acute care surgical units, but transferred to areas or specific positions in which they felt that the care they could provide to their patients was much more satisfying to them. This has been a positive change for all of them. Many of the participants have transferred to particular surgical units where there are longer stay patients. In this manner, the nurses felt that they have a greater opportunity to make connections with their patients to develop the therapeutic relationships that are important to them.

When I asked Jan (Participant #6) to share positive caring experiences, she had difficulty recalling such events. She identified quite clearly what caring meant to her, however, she could not remember specific events where she felt satisfied that she had

participated in a positive caring experience. When Jan discussed her new role as a nurse specialist, she began to recognize that caring as a concept in nursing means more to her now, in her new role, than it did when she was a general duty nurse. During our discussion, this revelation was enlightening to her. Jan felt that many of the last years in nursing had been somewhat suppressed in her mind, and it is only now that she realizes the importance of acknowledging the patient, listening to her/him and the importance of therapeutic relationships. "It's actually just over the last month that I would say I really learned that much more about the therapeutic relationship with the nurse and the patient in the new role" (Line 711-720). Jan shared that for the majority of her nursing career, prior to her job change, she focused her nursing interventions on skills and tasks, rather than looking at the whole person – body, mind, and spirit.

Sally (Participant #9) has recently begun teaching nursing students on an acute care surgical unit. It is in this new role where she has discovered mentoring students to be a positive experience in relation to caring. Here too again, it was not until our discussion that Sally reflected on how she demonstrates caring to students. This was not something that she had experienced as a student nurse, and had not thought about. Initially, she was concerned about the completion of tasks by the students. However, now, she redirects students to not only look at tasks, as she did early in her career, but to see the whole patient. Sally's experience as a clinical educator has been rewarding for her. She stated: "Maybe it's my way of contributing… maybe I can care more now, because I want to ensure that students identify caring in nursing, because I did not have that as a student. When I was a student, we just focused on the tasks. I did not have good role models" (Line 722-725).

Summary

Caring: An Intrinsic Ideal is comprised of five essential structures, reflective of the expressions of the participants: Nursing Foresight, Timing and Availability of Resources, Connecting, Advocating, and New Nursing Roles. These essential elements come together to form an architecture of positive caring expressions which represents an ideal caring world from the nurses stories.

Lamentations and Loss: Caring in the New Millennium

Lack of Time. All participants painted a vivid picture referring to the lack of time for spending with patients, particularly in the present work environment. "You don't have time to stop and talk with your patient. You have no time to try and find out from them a little more about their needs. It takes a little bit of time to get them to identify what they need to tell you. They need to establish a relationship with you and to establish their trust" (Participant #1: Line 332-337). Nurses value the time they spend getting to know their patients, but recognize that the amount of time at the bedside has decreased dramatically over the past few years. "It is sad when you have to run down the hallway just to give a pill. And the patient wants to talk and you just don't have the time. And there's so many interesting stories in this age group… anybody over 75 years who were in the war. It's just the way it is nowadays. Sad. (Participant #5: Line 190-203). June (Participant #5) continues "I need to be at the bedside to see the skin and find things out. That's where you carry on conversations. That's not what's happening, hence, that's where the caring aspect is going too. There is less time at the bedside. More time doing other things, and so I think people are suffering as a result" (Line 757-762).

Participants commented that there never seems to be enough time to address all the needs of the patient. Some things get left out or are not properly completed. Patients are being discharged home earlier and the amount of time spent teaching and preparing patients for discharge has decreased. Participants concluded that the numbers of surgeries have increased, but the amount of time spent with the patient has declined. Nurses complained that there is no time to perform proper head to toe assessments and no time to address emotional needs. Mary (Participant #1) expressed her frustrations:

> So you just have to say to the patient, I will try and come back later or you just brush them off somehow and make light of the situation, I'm late. And then you feel guilty when you drive home. On your drive home later you think to yourself, I wonder what they wanted to tell me about and you wonder, how could I have helped them out. What could I have done differently (Line 347-353).

Joanne (Participant #3) summarized best what many health care providers' experience. There is a fable that is often used to describe the health care system. It is the story, that Joanne shared, about pulling bodies from the river. The nurse pulls the bodies out of the river, but does not have time to go upstream to see who's pushing them in. Nurses working in institutions are positioned "downstream" looking after the people who have fallen into the river while struggling to keep them from drowning. Nurses do not have the time or resources to focus on health prevention and promotion on an acute care surgical unit. Along with feeling frustrated, the nurses expressed feelings of guilt that they were unable to provide quality care in a shortened time frame. The nurses also expressed anger with the health care system.

Lack of Support. Participants expressed the lack of support and availability of resources on the surgical units. Years ago, the head nurse or a team leader would be on available as a support to the nurses. This seasoned nurse was the pillar of the team and

was there to answer questions, assist when needed, and give guidance to new graduates and veteran nurses. Today, on many of the surgical units, a charge nurse or team leader does not exist, especially during evening and night shifts. Nurses feel very much alone. "And then you're wondering about something…is it normal…I don't know and I don't have the experience. You want to go and ask a nurse but they're running around doing their own thing, they don't have time to tell you…they just don't have the time" (Participant #7: Line 155-158). Jan (Participant #6) noted that "I can't remember somebody saying to me: 'What can I do for you, to help to lighten your load today?' I can't remember somebody being there to do that for me" (Line 571-574).

Sandra (Participant #7) shared her experience during an orientation to a surgical unit:

> I had a two-day orientation. The nurse responsible for my orientation was so busy. I was supposed to be shadowing her. She was so busy that she got me just doing her gopher work - you can do the medications and all that stuff…I know how to do medications, but what I need to know is the specifics (Line 119-125).

Sandra used the analogy "sink or swim" when she discussed her experience and the lack of support she was given during her orientation and subsequent shifts on the unit.

Sally (Participant #9), pregnant at the time, remembered a particular event where she stood at the bedside for hours attending to a patient who was hemorrhaging. She stood by the patient's side, instilling cold normal saline into a nasogastric tube in order to attempt to stop the bleeding. "There was no such thing as anybody extra or getting any help or calling anybody in, nothing like that. That's when I thought, I don't like this. I don't like this at all " (Line 254-256). Sally described this experience as a critical incident in her career where she felt very unsupported and alone. It was through this

experience that Sally came to some conclusions – that she needed support from others in order to care for her patients.

The participants remarked on the general lack of support from other members of the health care team. Participants encountered moments like this that left them feeling frustrated, exhausted, and alone. June (Participant #5) shared an experience that exemplifies this issue:

> There was a guy with bilateral knee amputations and he needed a lot of support at the bedside. He had a PCA morphine, but that was not holding him. I was trying to get hold of residents, who aren't answering their page to order additional pain medication. It's really frustrating for me because the patient is getting angry with me. The residents are coming to the ward saying, 'He shouldn't be in that much pain.' I said, 'Maybe it's just not physical pain, it could be the emotional pain.' I asked the resident if he had taken the time to find out what's wrong with the patient. He told me, that's your job. So we kind of had a little tit…argument out in the hall. Finally, I just called one of the anaesthetists … give him something. I've been trying to get a hold of somebody for an hour and I expect results (Line 429-474).

The Nursing Shortage. Without exception, all participants discussed the nursing shortage and the effect that it has had on their nursing practice. Working short staffed or working double shifts have become common and accepted as normal, in the hospital environment. Caring for patients without proper staffing levels transcends a negative experience for the nurse and the patient. On a surgical unit, late afternoon post-operative patients often return to the floor at the same time, making it difficult for the nurse to provide thorough care to all patients. Working short staffed, as well as being busy, were common expressions from the participants. "We need more staff so that our patients can get the care that they deserve, otherwise why do you get into a caring profession. You care about yourself and you care about others, and there has to be a balance in that" (Participant #4: Line 600-603).

Tasking

Unanimously, the participants discussed "tasking" versus "caring for the whole person." Time pressures, heavier workloads, increased responsibility, higher patient acuity, sophisticated technology, increased medical and nursing interventions for post-operative care, and tasking (what are described as routine psychomotor skills and nursing interventions) have changed the nursing environment. Tasking has become a predominant component of nursing care. The nurses talked at length about "always doing tasks." Nurses are so busy attending to multiple tasks that they feel the care they have provided is somewhat fragmented. Participants remarked on caring for the body only – not the whole person. "I have become task-oriented and I know that I have to do 50 things before the end of my shift. And in order to do that, you have to become very robotic and just do it" (Participant #1: Line 329-332). The nurses shared that because of the increase in tasks and nursing responsibilities to ensure all care is complete, they do not recall if the patient was a man or a woman – only a body in the bed, in a room, attached to a bed number.

Several participants remarked that contemporary, surgical nursing today is not nursing – it is tasking. Joanne (Participant #3) suggested a professional name change from "Nurse" to "Task Oriented Medical Assistant." Sandra (Participant #7) shared her experience multiple tasking to a point where she had no time to read a chart or find out more detail about the patient. Unexpectedly, the patient coded and died, and she was left feeling that she had not been unable to care for the whole person:

> I mean caring is what the essence of nursing is all about. Being able to care for the whole person. You feel like you weren't able to be there for that person and you worry, what if they die on you when they're not supposed to… it's hard to

> sleep at night and it's hard to move on when you feel so emotionally drained (Line 61-66).

Mary (Participant #1) recalled a recent experience where she floated to a surgical unit and was placed in an unsafe situation. She cared for a patient with a new trial method for pain control, utilizing a particular pump, with which she was unfamiliar:

> I questioned the nurse about this… I didn't feel like I was competent to look after this patient because I had never been orientated to this kind of pump. And the nurse said, 'We weren't really oriented properly either.' I talked to the charge nurse and she did end up allowing me to switch a patient. I found it very annoying that somebody would actually expect me to look after a patient when I've never been oriented to this new 'fangled' pump (Line 202-241).

Donna (Participant #2) summarized her expressions about tasking:

> You don't have the time that you want to spend with the patients. You're tasking all day. You've got 12 hours of running around doing the tasks. You complete the tasks and you're not looking at the patient, because you're consumed with technology and the tasking. So you feel torn. Technology requires monitoring and I find that that takes a lot of time from patient care. Nobody asked you if the technology is working, and if the desired goals have been met (Line 77-86).

Sandra (Participant #7) discusses her experience in surgery compared to palliative care. "Surgery is just constant tasking. It's a revolving door. It was just so busy, so acute, and yet you felt unfulfilled at the end of the day. It's not fulfilling doing psychomotor skills all day long" (Line 997-1004). Many participants reflected on feeling unfulfilled completing tasks all day.

June (Participant #5) reflected on her nursing experience in the past 20 years. "Back in the 70's when I was a nurse, things were very task-oriented. And then I saw improvements where we were becoming thinking people, looking at the body and the holistic health. What I'm seeing now is full reverse right back to everything being task oriented. That takes away from caring because you're so focused on time frames" (Line 687-694).

The participants agreed that new technology has saved steps and time for nurses, however, it has also increased the workload, by taking away time with the patient at the bedside:

> "You still have a million pumps, epidurals or PCA's that need monitoring closely. There's more work involved than there was 10 years ago with the increase of machines. You still have to go in there and check the machines, no matter what" (Terry, Participant #8: Line 427-429).

Increased Acuity Level. Participants commented on the increasingly complex acuity level of patients on surgical units. The number of staff, however, has not increased to compensate for the sicker patient. "The patients that are now coming post-operatively to the ward are patients that 10 years ago would be going to ICU or SICU (Participant #8: Line 421-423). Marcia (Participant #4) summarized her concerns best when she remarked: "The way things are going with the nursing shortage and the acuity level of the patients, compared to 10 years ago, we are unable to do what we need to do. To provide a more rounded or holistic kind of care to our patients" (Line 252-257).

Participants agreed that as the population ages, and medical and surgical technology advances, the number of elderly patients undergoing surgical interventions today has risen. Sandra (Participant #7) comments on her experience in cardiac surgery as she states that: "The acuity level has gone up. The average patient age is 80 or 90. They're operating on everyone. The acuity has increased because people, when they're living longer, have many more medical problems. So, you get this cardiac patient with all these other medical problems when they have surgery" (Line 575-591).

Several participants discussed that the type of shift and how the acuity level can impact on their ability to care:

> "On the night shift, I can get 9 or 10 (patients), depending on the acuity. If you've got someone that's very, very sick. Let's say you've got someone's who has come down from SICU or one that should be in SICU, but they don't have beds or they don't have a nurse up there to look after them. It is difficult if there are only 3 nurses on the night shift and everyone is busy. You just don't have time to do things" (Joanne, Participant #3: Line 238-248).

The Hospital Environment. Several participants described patients who were "off service" or "patients who were in the wrong place." Quite often, these patients were chronic care patients awaiting placement, but were placed, or displaced, on acute care surgical units. The nurses felt that between receiving fresh post-operative patients, preparing patients for discharge, and multiple tasking, patients awaiting placement or those who were longer term, seemed to get lost in the shuffle. Nurses felt guilty and upset that they were unable to provide some basic care needs or therapeutic interaction toward these particular patients. Donna (Participant #2) summarized these concerns through her narrative of feeling helpless with a patient who was in the wrong place:

> He couldn't go to the floor he was supposed to because of the bed shortage, so he came to our floor for pain management and to die. It was difficult because we did not know him. He was probably on the floor for two hours when he started feeling funny and he wanted someone to stay with him. He was afraid and I didn't want to leave him. He proceeded to blow his carotid artery. So there I was, with my hands around the patients' neck applying pressure. You can't leave the room and no one' s coming to help you. His family is not there. There was just nobody around. They were all too busy. He died, in my hands (Line 236-252).

Joanne (Participant #3) shared her story about an off-service patient on an acute care surgical unit. "We had a little chat, but I felt because I didn't have long enough to build a relationship with him, he could express himself. He found out he had cancer. So, that's where our caring falls down for a lot of nurses. Because we don't have the time to just go and talk to Mr. so and so" (Line 185-194).

Several participants commented on the physical environment of the units and the hospital, which does not consistently support a setting that allows nurses to care, to provide basic needs, and to meet the needs of the nurses. If the nurses' needs are unmet, this directly affects their ability to care for others.

> "They have to allow us an environment to meet standards. You can't say it's my obligation to maintain these standards if you don't allow me to do this. You can't complain about my charting if you don't give me a quiet, decent place to chart. The conference rooms are small and people are eating their lunches in there and making private phone calls. I'm trying to focus and get my charting done" (Wendy, Participant #10: Line 790-819).

Several participants commented on the lack of "space" for nurses. Other than the cafeteria, which serves staff, patients and visitors, there is no environment for nurses to go for a break away from the ward. Joanne (Participant #2) provided the best summary of the hospital environment:

> We don't have any place to get away, where you can just pretend you're somewhere else. And pretend you're not there. It makes it hard to care when you can't get away for a break. You should be able to get away somewhere quiet when you're working in a very, noisy, busy environment.... I watch the other staff and they get very agitated and you can just see they're sometimes frantic. I don't want to be like the others. I don't want to become like the group that's switched off and really doesn't care any more (Line 384-404).

Lack of Continuity of Care. Several of the participants, particularly the respondents who have seen major changes that have occurred on surgical units in the past 10 to 20 years, commented on the lack of continuity of care. Sandra (Participant #7) provided a summary of her experience. "With surgical nursing, you usually have a patient for one shift only. If you're lucky you might get them for two. I would come in the next day and ask, 'Why don't I get this patient again?' I was told that we had to mix up the patient load because we're more acute" (Line 370-377). Patient assignments are based on acuity level and not necessarily the relationship the nurse has established the

previous day. When assignments constantly change, continuity of care breaks down. Patients may have several different nurses every day for the duration of their hospitalization.

In contemporary surgical practice today, patients are not routinely admitted the day prior to their surgery. The nurse who receives the patient post-operatively has never met the patient before. Just as quickly as the nurse has met and cared for them, the patients are ready for discharge home. Donna (Participant #2) provides a summary that reflects the environment today:

> I nursed when there was total patient care. Patients would come in the night before their operations. You actually had time to talk, to be able to spend time with the patients and get a lot of information about them. You had the opportunity to let them have a bit of a longer hospital stay experience. As a result, they left feeling comfortable. Now the patient comes in to the hospital the same day of surgery. They end up in three different places from start to finish and they hardly even know their nurses name (Line 1046-110).

Nurses are left feeling frustrated that they are rarely able to provide continuity in their care.

Family. Participants remarked positively on connecting with the family, in response to expressing what caring means. Being able to connect with the patient and the family was identified as an integral part of nursing and caring. However, several nurses also identified that the family can also be seen as a barrier. Family can be demanding, which can increase the workload for the nurse. Families can now visit 24 hours a day, which was also discussed as a hindrance to patient care. For many patients, having family near is comforting, however, when procedures need to be completed, or if there are several family members asking the same questions, family can take up extra time. This can impact on the nurses' work by delaying care for the patient or for other

patients. "I think it is very hard right now with patients' families… now we've changed visiting hours to 24 hours around the clock and families are coming in and out reaming out the nurse because their perception of what you do all day is very different. They think they are advocating for the patient, but they are not. I think they interfere with patient care" (Participant #2: Line 102-122).

Sandra (Participant #7) reflects on the differences on working with families in palliative care versus surgery. "I think surgical nurses see family as a bit of a burden. The family is in the room all the time and they won't leave" (Line 466-469). Sandra commented that it was a time factor that often deterred time with the patient. She remarked that if she had time in surgery, she welcomed questions from the family. In the acute care setting, the focus is on tasks. Quite often family visits impede upon the completion of interventions by the nurses. In palliative care, the family is a major focus in the care of the patient.

Self-Preservation. Several nurses talked about peers who shut themselves off emotionally from their patients. This appears to be a coping or self-preservation mechanism developed over time as a result of a non-supportive environment on acute care surgical units.

> "Because you look after these people 12 hours a day, and you get to know them, and it's hard on you. To be a caring nurse takes a lot out of you personally. A lot of nurses just can't go there anymore. A lot of nurses prefer tasking because they don't want to get know their patients any longer because it's too difficult. It's too difficult to pick someone up and drag and support them through their recovery. Doctor's don't do that. It's the nurses who do that. It's the nurses that give the patients strength and energy and encouragement. You want to be able to sit there and let them talk to you, but part of you doesn't want to hear it either. Well sometimes you want to save your sanity, right? You get too close. It's a fine line sometimes between caring, being involved and an aloofness in order to cope with the situation" (Donna, Participant #2: Line 289-340).

Many participants referred to contemporary surgical nursing practice as unfulfilling and robotic. Sally (Participant #9) discussed a point in her career where she thought of leaving the profession:

> I decided that I was going to get out of nursing. I wasn't doing all the things I was taught to do. I did some soul searching, and I realized that I'd never be able to give 100% to eight patients in an eight-hour shift ever. But, I could give 100% to one or two patients, and that took a lot of pressure off me. I just didn't have enough emotional energy to give to my patients and to my own family. I would distance myself from my patients emotionally. So it became just go in, do your medications, your assessments, your charting, and go home. There was a price to be paid for that I think. I think part of that kind of distancing helped to burn me out.... I was getting frustrated. I sat down and looked at my priorities.... I decided to give of myself to at least one or two patients and to do my very best (Line 181-252).

Emotional attributes of caring, from the participant's expressions, appear to be an unpleasant experience. "Because nurses do not have the resources available, they can not cope and they just shut down. They continue to complete physical care for patients because the emotional care is too painful" (Participant #9: Line 271-282). The nurses expressed that in the current work place, there is just no time to address all needs of the patient, which is not caring for the whole person.

Participants commented on coping skills of the nurses they work with.

> "I don't think that nurses don't want to care, it's just that they don't have time to care. We care and we want to do the best that we can, but we also don't want to take it home. After we leave work, we then internalize it and cannot free ourselves of the burden, hence, it is getting to the point where caring becomes superficial - as a survival mechanism. We don't want to care too much because if we do, we can't get the work done. To say the least, caring is very stressful" (June, Participant #5: Line 1072-1095).

One of the participants shared a narrative, quite divergent from any of the other respondents. Marcia (Participant #3) commented toward the end of the interview that she is able to cope in her job on a surgical unit by attempting to take time during her

breaks to rejuvenate. She typically does not join the other staff during break time. She may walk outside or sit alone. Marcia does not engage in negative discussion about work conditions or complaints about staff. "I'm considered almost like a traitor on my unit because I don't complain about the conditions on our unit. I try to encourage the other staff members that I work with because complaining will not get us anywhere" (Line 587-590). Marcia feels like a traitor because she tries to remain positive about the work conditions, while co-workers do not. She expressed that many colleagues are negative and tend to ruminate over the same issues and problems on acute care units, rather than attempting to find positive aspects of their jobs, and in their own lives. Marcia attempts to transcend her positive nature to her patients as well. She tries to look beyond the tasks, to see the patient beyond the highway of tubing, to take the time to interact with the patient, and address their concerns. She feels unsupported by her colleagues and is determined to provide good quality care and to do her very best for the patients she cares for.

Caring for Each Other. Several participants remarked on not being able to care for each other, nor for themselves. In order for nurses to care, they need to care for one another. June (Participant #5) epitomizes the participants' expressions. "I think nurses are doing an injustice to each other, because we're not taking care of each other any more. The environment today is to get the patient out of the hospital and to just get the nurse's shift over. Tomorrow is another treadmill" (Line 381-384).

Participants commented on the increase in multiple tasking, working short staffed, low morale, and lack of support from unsympathetic peers. Sally (Participant #9) offered a somewhat amusing story. Despite having a sore leg (deep vein

thrombosis) for the past few years, Sally continues to work as a nurse. She limits herself to eight-hour shifts, as longer hours tend to make her leg worse. This particular day, she was asked to stay and work longer:

> I have this rotten leg and it's really swollen, but my colleagues say to use the anti-embolitic stockings and take Coumadin. They tell me I look fine. The joke among the nurses is that if any of us had a heart attack, they'd bring the paddles in, defibrillate us and we'd get up and finish our shift (Line 492-505). I wonder if they don't just get a little burnt out from always caring for others (Line 522-523). Sally continues that "nurses are very interesting because for people who go into a caring profession, they are so uncaring to one another. That is not to say it is everyone, but often it is the case (Line 516-518).

Sandra (Participant #7) shared a negative experience in which the patient she was caring for died unexpectedly. She was unprepared for this event. After the patient died, she felt emotionally exhausted. "I called the supervisor and told her that I'm wasted. Can I get help? I was there doing paperwork for two hours and it was hard to focus. There was no help available" (Line 84-94). There was no support for Sandra, no debriefing or counseling for her after this traumatic event. There was no caring and no time out for her to regain her energies and composure.

Transcending caring to others begins when nurses feel that they are cared for and supported by each other in their work environment. Nurses need to feel accepted by one another so that they may create a caring milieu for the patient and the family. June (Participant #5) shared her experience as a nurse 20 years ago:

> I find we're becoming a more selfish society than when I started nursing years ago. Everybody was looking out for the patient. We were all there to work together, and now it's like, we're all busy people and we are not concerned about the other team members… in order to feel and provide good caring and good nursing, we need to start caring about each other (Line 992-1000).

Lack of Mentoring. Mentoring new graduate nurses was discussed within the context of contemporary practice today and in the future. Participants reflected genuine concern for new graduate nurses and the lack of role modeling by senior staff. Participants acknowledged that many senior nurses are "burned out" and are poor role models for future graduates. Many nurses refuse to mentor, preferring to complete their tasks at hand. Mentoring is seen as an additional burden to their already heavy workload:

"There's a lot of pressure now on senior nurses because there tends to be many new grads who are not ready to take care of patients. As a result, the experienced nurses are caring for the more acute patients. To maintain your sanity or motivate yourself to go to work, you have to disassociate yourself from others, students, and staff, and that's taking away the caring aspect" (Donna, Participant #2: Line 1191-1207).

Summary

Participants shared a host of negative caring experiences. Factors that affect caring were identified. The experiential structures that comprise the negative caring experiences and the factors that affect caring were combined to formulate the theme: Lamentations and Loss: Caring in the New Millennium. The essential structures included: Lack of Time, Lack of Support, The Nursing Shortage, Tasking, Increased Acuity Level, The Hospital Environment, Lack of Continuity of Care, The Family, Self-Preservation, Caring for Each Other, and Lack of Mentoring.

Accentuating Care: Ideal versus Reality

Nursing: More than Just Tasks. Participants unanimously reflected on the importance and the value of caring in nursing practice. The respondents emphasized that nursing is more than just tasks. It is the ability to see the big picture and to see the whole patient; not the patient as a diagnosis, or a bed number, or a body. Taking the time to

explain, teach, and advocate for patients are valued aspects in the realm of caring. "Technical tasks of nursing have to be done before the end of the shift, meanwhile you have left out other important aspects that deals with caring. Caring often gets left behind, because of the tasks you need to complete" (Participant #1, Line 294-300). The ability to know the patient and understand the patient, in order to nurse and in order to care, was expressed as the essential element in the whole enterprise and professional modus operandi. However, although the value of caring has been expressed as critical to nursing, the act of caring is hindered in the context of contemporary practice.

Summary

In this chapter, the findings of the research were presented in order to provide answers to the research questions and formulate themes that reflected the life-world of nurses who work in contemporary surgical nursing. Essential structures and elements from the data emerged toward the development of four main themes. The participants' stories and experiences have been highlighted and categorized into themes, in an attempt to describe the experience of caring from the perspective of surgical nurses who work on acute care surgical units.

CHAPTER FIVE: DISCUSSION, RECOMMENDATIONS, AND CONCLUSION

Introduction

The final chapter includes a discussion of the research study, which is based on the findings presented in the previous chapter, a review of Chapter Two, and the relationship of the findings to the sensitizing framework. Recommendations for the nursing profession in the areas of practice, administration, education, and research are delineated before drawing final conclusions.

Discussion

The discussion section will focus on the relationship of the findings (major themes) to the following three areas: the research sample, the nursing literature presented in Chapter Two, and the sensitizing framework by Morse et al (1990). Morse's et al (1990) five epistemological perspectives include caring as: a Human Trait, a Moral Imperative, an Affect, an Interpersonal Interaction, and a Therapeutic Intervention. The discussion intends to clarify the recommendations, which resulted from the findings of this study.

Relationship of the Findings to the Sample

The sample summary was constructed and presented in detail (see Table II, p.52). Sample attributes were analyzed, and as a result, there are intrinsic components of the findings that are worth discussing.

Participant Response. The nurses' response to participate in this study was gratifying. After I posted the Invitation to Participate in the Research Study (see Appendix A and C, p. 131 and 133) on various surgical units, I immediately received responses from potential participants. I spoke with each nurse to determine if the

inclusion criteria had been met and to establish a convenient interview time. All 10 participants were pleased to be able to take part in this study. Participant response is congruent with similar studies in the nursing literature. Idvall and Rooke (1998) conducted focused interviews with 20 nurses who work on surgical units. Williams (1998) interviewed 10 surgical nurses, while Clarke and Wheeler (1992), using phenomenology, interviewed six practicing nurses. A phenomenological study by Forrest (1989) conducted interviews with 17 nurses, which is more than the approximate number of 10 participants in qualitative research.

Based on the response by the participants, I believe that the nurses working in acute care practice welcomed the opportunity to discuss their perceptions of caring and how it affects their ability to function in the context of the present working environment. Upon completion of the interviews, I was assured that nurses value caring in their practice and that each nurse struggles to maintain quality nursing care everyday. These findings are congruent with other qualitative studies on caring (Forrest, 1989; Clarke & Wheeler, 1992; Williams, 1998; Idvall & Rooke, 1998) which found that nurses place a high regard on caring.

Age and Nursing Experience. The average age of the participants was not determined as they were asked to provide an age range in the inclusions criteria. However, the sample identifies that the majority of the nurses were between 35 and 45 years of age. In the year 2000, the average age of the nurse working in Manitoba was 43.2 years of age (College of Registered Nurses of Manitoba Database, 2000). Studies by Idvall and Rooke (1998), Williams (1998), Clarke and Wheeler (1992) and Forrest (1989) reported an age range of participants between 21 and 52 years of age. The findings

from the literature are congruent with this study, however, the majority of the participants were between 35 and 45 years of age, which is suggestive of an aging workforce in nursing. The Canadian Nurses Association (1998) reports that by the year 2011, the average age of the nurse will be 48, and thus, the profession will be largely composed of nurses nearing the end of their working life.

Of the six nurses, ages 35 to 45 or older, four had recently moved from acute care surgical practice to surgical units that includes caring for patients who are longer term. Participants expressed a desire to work in an area where they felt they could provide the care they wanted to give and to be able to have time to get to know the patient. They had all worked on "fast paced" surgical units and felt it was time to move to an area where they were more likely to be satisfied that they had provided quality care, to the best of their ability. These findings are congruent with a Canadian study by Oberle and Davies (1993) which found that many nurses had become disillusioned with the profession. Their stories echoed the findings my study, in that the participants shared dissatisfaction within the nursing profession, as they believed they were unable to provide quality care to their patients. Hartrick and Hills (1993) studied the stresses of nurses working in acute care environments. The nurses identified that they had no emotional time for their patients and family and felt a general lack of support from staff around them. Three of the four participants, in my study, moved from the surgical float pool to a particular unit where they felt support from staff. Support and caring for each other was discussed as a positive attribute. The participants agreed that in order to provide care for patients, it was important that they worked in an environment that fostered caring, particularly from co-workers. These findings may suggest that nurses who work in acute care areas for a

considerable amount of time, eventually seek work in other areas in which they can develop longer, therapeutic relationships with patients and better working relationships with staff. After years of working in a surgical float pool, where bonds are not often established between float nurses and staff, three of the participants made the decision to make a more permanent move. Garrett and McDaniel (2001) suggest that social climate, particularly in times of change in the health care system, can help buffer the negative effects of a crisis. A perceived lack of social support may have a negative effect on nurses, leaving them feeling dissatisfied with their work.

Change in Job Position. There were six participants who identified a recent move or change in position. As discussed in the findings, one nurse moved from surgery to palliative care. She clearly stated that she would have considered staying working in acute care, however, she values the importance of connecting with the patient and family and she felt she was not able to make those connections on a surgical unit. The nurse discussed the differences between caring for patients in surgery versus palliative care, and expressed that, in general, positive caring experiences occurred more often in palliative care than in acute care. Garrett and McDaniel (2001) discuss that hospitals are changing rapidly and the demands of caring for more patients in less time is real, particularly on surgical units. Delay of admissions and the speed at which patients are discharged places considerable stress on the nurse. The ability to care and prepare patients for surgery under time constraints is overwhelming. Many nurses feel they can not continue to nurse in this type of environment. Unfortunately, some nurses begin to withdraw from patients and staff, or they choose to work in areas where they feel satisfied with the care they can provide. Other nurses attempt to make the best of the

environment and try to hold on to the positive experiences that do occur. Nurses truly do want to make a difference to ensure that the patient has a positive outcome. One nurse stated, "If we leave, who will look after these patients. Someone has to be here for them" (Participant #9, Line 943-944).

One of the participants recently changed her position from a general duty nurse to a clinical nurse specialist, on the same surgical unit. This nurse shared how this new position has given her insight into the importance of the development of therapeutic relationships, as part of caring. In this role, she feels that she can nurse the whole patient with less emphasis on nursing tasks. During the interview, she came to a revelation that although she values the importance of caring, she really did not conceptualize what caring meant until she changed her job to a role as an educator and specialist. Does this suggest that nurses are too busy too care? Are they so busy that they do not have the time to reflect on caring? Perhaps for the nurses who can not see beyond nursing tasks, caring is not conceptualized in their minds until they have reached a point in their career where they are not satisfied with their work and they realize that performing tasks alone is just not enough. Clarke and Wheeler (1992) share that people have to practice caring before they can experience its meaning for themselves. In other words, nurses need the opportunity to practice caring or to conceptualize what caring is. However, this may not be possible on fast paced surgical units in the new practice environment.

Another participant continues to work on a surgical unit that cares for long term patients while also working part-time as a clinical educator with third year nursing students. She discussed her experience with these students and how this role has personally and professionally helped her to be able to express caring behaviors and assist

students to value the importance of caring. Simonson (1996) explains that if one accepts that caring is basic to nursing, then it is important to explore how to demonstrate caring and attempt to understand how to incorporate caring in nursing practice. The author continues that educators need to exhibit caring as a way of being, in order to teach caring to nursing students. This is why it is important that seasoned nurses and experienced educators are role models for nursing students and new graduates.

Relationship of the Findings to the Nursing Literature

This section of the discussion considers how the findings from this research are related to the nursing literature presented in Chapter Two, and how the literature is congruent with the extracted major themes from the findings. It should be recalled that the number of quantitative studies of nurse caring perceptions exceed the qualitative studies (see Table I, p.18). Studies on caring from the perspective of the patient exceed the number of studies from the nurses' perspective. However, qualitative research in this area has emerged during the past 10 years. Several researchers (Bertero, 1999; Williams, 1998; Nelms, 1996; Clarke & Wheeler, 1992; Forrest, 1989) conducted studies that explored nurses' perceptions and experiences of caring in relation to quality nursing care. Williams (1998) specifically interviewed surgical nurses describing quality nursing care, while the other researchers interviewed nurses who worked in a variety of settings, including medicine, surgery, psychiatry, and pediatrics. Idvall and Rooke (1998) identified important aspects of nursing care on surgical wards, as expressed by nurses. Studies on caring, from both nurse and patient perspectives, have traditionally been conducted in specialty areas such as critical care, peri-natal nursing, psychiatry, oncology, and pediatrics. The number of qualitative studies of caring in acute care,

medical and surgical wards, is minimal as compared to the quantitative studies. The four Major Themes and Supporting Essential Structures from the findings have been summarized (see Table III, p. 91) to assist in the recollection of the themes, while understanding how the themes relate to the nursing literature.

Table III – Major Themes and Supporting Essential Structures

Major Themes	**Supporting Essential Structures**
Nursing Care as Whole-Person Encounters	Body, Mind and Spirit
	Beyond Direct Patient Care: Nursing the Family
	Creating a Caring Environment
	Anticipatory Needs
	Teamwork
Caring: An Intrinsic Ideal	Nursing Foresight
	Timing and Availability of Resources
	Connecting
	Advocating
	New Roles
Lamentations and Loss: Caring in the New Millennium	Lack of Time
	Lack of Support
	The Nursing Shortage
	Tasking
	Increased Acuity Level
	The Hospital Environment
	Lack of Continuity of Care
	Family
	Self-Preservation
	Caring for Each Other
	Lack of Mentoring
Accentuating Care: Ideal versus Reality	Nursing: More than Just Tasks

Qualitative Studies – Surgical Nurses' Perspectives of Caring

The aim of this analysis is to determine whether the findings of this project compare and contrast with previous studies of caring from the literature. The findings from four qualitative studies (phenomenology, grounded theory, and focus group interviews) have been chosen for discussion, as the respondents from these studies are identified as nurses who work on surgical units.

Idvall and Rooke (1998) conducted focus group interviews (N=20). The goal of the study was to seek out clinical nurses' perceptions of important aspects of nursing care and how it might impact on the quality of care on surgical wards. A general feature that stood out included obstacles to good quality nursing care, followed by a lengthy discussion about how the nurses "did their best" under the circumstances given, in the new practice environment of acute care surgery today. When the participants were asked about good quality care, their expressions were suggestive of the negative aspects of care, rather than positive aspects. These findings would concur with expressions by the nurses in my research study, as the number of negative caring themes exceeded the positive caring themes.

Idvall and Rooke (1998) condensed their findings into two dimensions of caring: prerequisites to caring and elements of performance. Prerequisites to caring included an adequate number of staff, access to equipment, positive staff morale and attitude, teamwork, and professional development. Positive caring expressions in the Caring: An Intrinsic Ideal theme included Timing and Availability of Resources. Caring was dependent upon having adequate nursing staff and support staff available. In these

particular situations, the nurses described how they felt they had delivered good quality nursing care and felt satisfied with the outcome of the scenario.

Elements of performance in the study by Idvall and Rooke (1998) included anticipating potential problems, performing skills safely and accurately, adequate time for pre-operative and post-operative teaching, educating the client, advocacy, and providing privacy and respect. In my research, participants expressed Nursing Foresight, or anticipating potential problems, as positive caring expressions in the Caring: An Intrinsic Ideal theme. When the nurses in this study described Nursing Care as Whole-Person Encounters, aspects such as advocating, educating, trusting, and respect for the patient were identified. The findings of this research fit with the analysis described by Idvall and Rooke (1998). Aspects of good quality nursing care coincide with the components of the themes Nursing as Whole-Person Encounters and Caring: An Intrinsic Ideal. I believe that positive aspects of caring are linked closely to what nurses believe good quality care is and how satisfied they feel that the care they have given is optimal, in the context of contemporary practice.

Williams (1998) explored the delivery of quality nursing care from the perspective of nurses' working on surgical wards (N=10). The meaning of quality nursing care included meeting physical and psychosocial needs of the patient and the family, establishment of trust and rapport, and connecting. Williams (1998) study identifies that a greater emphasis was placed on meeting patients' psychosocial needs rather than physical care needs. My research endorses Williams (1998) study on caring, as the themes describing Nursing Care as Whole-Person Encounters and Caring: An Intrinsic Ideal were similar. Themes from the findings posit the importance of nursing not just the

body, the physical, but also the mind, and spirit. Nursing Care as Whole-Person Encounters for the nurse included going beyond patient care to include the family. In this theme, the sub-theme Creating a Caring Environment, contained attributes that included connecting, advocating, and building trust between the nurse and the patient and the family.

Williams (1998) study also discussed factors that hindered the ability of the nurse to consistently provide quality care. Essentially, the limited amount of time and availability of resources impacted on the delivery of nursing care. The increased workload of the nurse on an acute care surgical unit coupled with insufficient time to complete the assignment was directly related. The nurses felt dissatisfied, frustrated, and guilty when they were unable to deliver quality care. The findings from my research are congruent with Williams (1998) study. The theme Lamentations and Loss: Caring in the New Millennium and the factors that impact on the negative descriptions, outnumber the positive. The lack of time to complete nursing care, the increased workload on surgical units, and the lack of resources were described at length by the participants throughout their interviews.

A study conducted by Clarke and Wheeler (1992) investigated the meaning of caring from the perspective of nurses who work on acute medical and surgical units (N=6). Phenomenology facilitated the essential structures: being supportive, communicating, pressures, and caring ability. The four categories or themes by Clarke and Wheeler (1992) support the themes and underlying structures in the study under review. Offering support and communicating with the patient coincides with the theme Nursing Care as Whole-Person Encounters and the supporting sub-themes in the findings.

This theme included important aspects such as communicating, listening, advocating, building trust with the patient and family, performing the little things that are important to the patient, prioritizing, and acknowledging patient effort. The last two categories in Clarke and Wheeler's (1992) study were pressures and caring ability, which refers to the natural consequences of caring for others, while feeling not cared for themselves. The nurses described lack of support from their peers and the lack of opportunity to release stress and thus maintain and enhance their caring ability on the ward. Stressors included lack of resources, equipment, and staff shortages. The themes and essential structures of my research concur with the study by Clarke and Wheeler (1992). Lack of Support, Self-Preservation and Caring for Each Other were essential structures of the theme Lamentations and Loss: Nursing Care in the New Millenium.

An investigation of caring by Forrest (1989) was identified in the nursing literature as the only Canadian study similar to the present research. Respondents (N=17) in the study by Forrest (1989) worked in medicine, surgery, psychiatry, and pediatrics. Forrest's (1989) categories and themes were exhaustive and specific. The main categories included: involvement, interacting, giving of oneself, the patient first, frustrations, coping, comfort, and support. Generally, the findings describe caring as first and foremost in relation to nursing care. Being able to put oneself in the patient's position was delineated as important. Caring included more than physical care, involving patient and nurse in the caring interaction. The capacity to be caring was sustained and supported through co-workers and the amount of teamwork on the unit. Nurses who felt cared for by peers and supervisors were able to be caring toward their patients. Findings from Forrest's (1989) research are

congruent with the results of my study. The categories and theme clusters fit with all of the themes: Nursing Care as Whole-Person Encounters, Caring: An Intrinsic Ideal, Lamentations and Loss: Caring in the New Millennium and Accentuating Care: Ideal versus Reality.

Relationship of the Findings to the Sensitizing Framework

The sensitizing framework provided the researcher with a perspective and a guide of the phenomenon under study – caring. The following discussion is to determine how the findings fit with the framework and if the findings are supported by the literature.

Five Perspectives of Caring. The conceptual framework by Morse et al (1990) attempts to clarify the complexity of caring in the literature by providing an interrelationship of diverse views (25 nurse theorists), categorizing five epistemological perspectives on the nature caring (see Table IV, p. 97). Morse et al (1990) developed five perspectives, not intended to be rigid, but meant to clarify the complexity of the literature and to imply relationships. The discussion in this section will consider the following three questions. First, are the framework and the findings congruent and how do the findings relate to current literature? Second, did the sensitizing framework guide the research, and finally, are any modifications to the framework required, based on the findings?

Table IV – Summary of the Sensitizing Framework and the Major Themes with Supporting Essential Structures

Sensitizing Framework – Five Perspectives of Caring – Morse et al (1990)	Major Themes and Supporting Essential Structures
1. Caring as a Human Trait	**Nursing Care as Whole-Person Encounters** Body, Mind, and Spirit
2. Caring as Moral Imperative	**Nursing Care as Whole-Person Encounters** Teamwork **Caring: An Intrinsic Ideal** Timing and Availability of Resources **Lamentations and Loss: Caring in the New Millennium** Lack of Time Lack of Support The Nursing Shortage Tasking Increased Acuity The Hospital Environment Lack of Continuity of Care Lack of Mentoring
3. Caring as an Affect	**Caring: An Intrinsic Ideal** Nursing Foresight **Lamentations and Loss: Caring in the New Millennium** Tasking Self-Preservation
4. Caring as an Interpersonal Interaction	**Nursing Care as Whole-Person Encounters** Creating a Caring Environment Beyond Direct Patient Care: Nursing the Family **Caring: An Intrinsic Ideal** Connecting Advocating **Lamentations and Loss: Caring in the New Millennium** Lack of Time Family **Accentuating Care: Ideal versus Reality**
5. Caring as a Therapeutic Intervention	**Nursing Care as Whole-Person Encounters** Body, Mind, and Spirit Creating a Caring Environment **Lamentations and Loss: Caring in the New Millennium** Lack of Time Lack of Support Tasking

Congruency with the Findings

The five perspectives by Morse et al (1990) and the findings from the current study will be discussed by linking the themes Nursing Care as Whole-Person Encounters, Caring: An Intrinsic Ideal, Lamentations and Loss: Caring in the New Millennium and Accentuating Care: Ideal versus Reality within the sensitizing framework.

Caring as a Human Trait. From this perspective, caring is an innate trait or mode of being and is viewed as an essential part of human nature. Morse et al (1990) suggests that caring as a human trait is heavily influenced by life experiences and may also be seen as a motivator to nursing caring. Actions by the nurse toward the patient are initiated when patient self-care can no longer be maintained. Participants provided data to support the essential structures that comprise the theme Nursing Care as Whole-Person Encounters. Caring was expressed by several participants as a learned behavior that is based on personal past life experiences. Caring is influenced by past experiences with family, friends, and past and present role models in nursing education. Nurses identified observation of co-workers as of great importance in how they deliver nursing activities in a caring way. Several participants spoke of fellow nurses they admire, and the manner in which they care for their patients. Nurse theorists in this perspective emphasize that in order to carry out nursing interventions, caring is essential. Simonson (1996) states that you have to care about people in order to be a nurse.

Caring as a Moral Imperative. This category implies caring to be a moral virtue. Nurses are concerned about their conduct toward patients - what is good and decent. Caring, as a moral ideal, enables the nurse to identify appropriate actions of nursing care in the context of what the patient requires and what the nurse has identified is necessary

to the well-being of the patient. This implies identifying and anticipating patient problems and conducting oneself in a manner that supports standards and principles within the realm of nursing and within human nature.

Teamwork was identified by the participants as an essential structure in the theme Nursing Care as Whole-Person Encounters. The development of working relationships with peers was considered an important aspect when the nurses discussed what caring meant to them. Participants reflected that knowing that they had support from the health care team was essential in order for the nurse to be able to care for their patients and to be able to deliver care within the standards of nursing practice.

Timing and Availability of Resources was identified as a positive caring expression, in the theme Caring: An Intrinsic Ideal, when the described situation was coordinated in a manner that was favorable to the patient, family, and the nurse. Participants shared stories in which the timing of the event was "right" and the support from members of the health care team was shared. Nurses understand and envision ideal nursing care, however, they are not always able to provide care in the manner in which they would like. There appears to be a conflict between desired goals and actual performance of care. The goals for patients may be dependent upon several factors, including how nursing staff work together as a team and generally, the time available to complete care.

While the nursing profession holds caring as a moral virtue, current working conditions frequently limit opportunities to provide care and uphold the moral ideal. Perhaps caring as the essence of nursing may need to be re-evaluated. Has caring changed? Is caring possible in contemporary practice? Is modern nursing practice placing emphasis on a more scientific frame of reference resulting in less value for

caring? And finally, is caring regarded as something lesser than nursing interventions or tasks? The theme Lamentations and Loss: Caring in the New Millennium identifies essential structures that outlines factors which may hinder nursing care. Lack of time, lack of support, the nursing shortage, multiple tasking, a general increase in workload, increased patient acuity, and the lack of continuity of care in the hospital environment were discussed as negative elements. Unfortunately, all of these factors can also contribute to unsafe practice.

Morse et al (1990) explains that caring as a moral imperative provides the basis of all nursing actions. If the nurse is experiencing a general lack of support in the work environment, then it is difficult to care for others. Support from nursing administration was also shared as an important element that either helped or hindered nursing care. Stordeur, D'hoore, and Vandenberghe (2001) maintain that a nurse leader can help to buffer the effects of a demanding environment by projecting a leadership style that supports the needs of the staff nurses. The nurse leader must have continuous awareness of the day to day stressors that occur on the unit and be able to have the ability to make changes. The elimination of the head nurse position is a possible source of the problems that exist. In many large institutions, nurse managers are accountable for more than one unit, which decreases their involvement and presence on the unit. In this case, it may be a challenge to have a true sense of problems, and in particular, how staff develop and maintain teamwork.

Cronin (2001) delineated that in general, nurses on an acute care unit have little time to express their emotions and concerns. Formal support on the unit was not available. The nurses in this study used informal supports such as co-workers, family, and

friends outside work to help cope with stress. However, there needs to be a balance between support at work and at home in order to help nurses survive and thrive in the workplace.

Mentoring new staff and students was discussed in the theme Lamentations and Loss: Caring in the New Millennium. In current practice, there is a significant lack of guidance from senior nurses who are feeling burned out and emotionally exhausted. Nurses working under time constraints with an unrelenting heavy workload do not have time to spend advising new staff. Caring for future co-workers, although recognizing that mentoring is important, yet somewhat impossible at times, is frustrating for nurses. While the participants recognized the importance of mentoring to ensure quality care, the nurses felt that there is only so much "caring" they can give. Emotional exhaustion is a component of burnout, according to Stordeur et al (2001). Loss of concern for others, including patients and staff, eventually progresses to personal feelings of inadequacy and failure, which can have a tremendous impact on job satisfaction.

The loss of the head nurse or middle management position may also have an impact on mentoring new staff. If the head nurse, once the anchor of the unit, is not visible, who is the role model for new staff? Often it is the senior nurses who mentor new graduates, and if they are exhausted, how does this affect the next generation of nurses on acute care units?

Caring as an Affect. Caring from this perspective is described as an affect, as an emotion, or as a feeling of compassion that somehow motivates the nurse to provide care to the patient. It is suggested that these feelings must be present in order for caring to occur. Morse et al (1990) continues that part of the art of caring is the ability of the nurse

to become skilled in creating a variety of ways which express caring. This includes placing oneself in the patient's position and understanding what it must be like for them. Theorists, from this perspective, state that caring is assisting patients with activities of daily living, which can range from very simple to highly complex nursing interventions.

The theme from my study that corresponds to caring as an affect is described in Caring: An Intrinsic Ideal and is supported by the essential structures. Caring as an affect is a complex perspective and could possibly include an endless variety of actions or forms of caring by the nurse that are expressed. Participants described positive caring expressions in the Nursing Foresight structure as have the ability to identify the patients' physiological needs and psychological state. Optimal analytical skills by the nurse assist to identify verbal and non-verbal cues from the patient. Today, more than ever, nurses practicing in acute care must have a strong knowledge base in pathophysiology and nursing care and have excellent decision making skills in order to cope in this environment. This theme endorses the perspective that the nurse needs to be able to place oneself into the patient's position, which also allows the nurse to consistently consider placing the patient first, both in mind and in action. Caring is genuine – a genuine interest into the well-being of the patient, encompassing body, mind, and spirit.

The theme Lamentations and Loss: Caring in the New Millennium revealed a unanimous concern from the participants, that a dramatic increase in sophisticated technology has become common in acute care. The amount and variety of psychomotor skills and nursing interventions required by surgical nurses has increased dramatically. Surgical patients return to the ward post-operatively with wide variety of tubes, drains, and machines. The nurses in my study suggested that since technological demands have

increased, the development of a caring feeling toward the patient may never be established. Participants shared that, in acute care, nurses are consumed with nursing tasks, which may devalue the importance of caring as an affect. Participants described feeling frustrated with the multiple nursing tasks that they had performed – attending to the physical needs of the patient and not the emotional care. Can today's nurses not see past the technology? Can caring be integrated into this complex patient care environment? How can caring be instilled or internalized? Bolton (2000) stresses that professional care not only lies in the accomplishment of technical tasks, but in the creation of the emotional climate. The author describes emotional work as a "gift" in the process of nursing labor. However, emotional work should be equally valued with technical labor. Bolton (2002) continues that emphasizing technical skills in nursing detaches from emotional skill. Machines complement care, but do not replace care that nurses provide.

The essential structure Self-Preservation assisted in the development of the theme Lamentations and Loss: Caring in the New Millennium. Participants reflected on co-workers who they identified as "shutting down" from emotional aspects of patient care. Caring was described as emotionally exhausting and in order to cope, nurses preferred to stay focused on nursing tasks and interventions, rather than displaying compassion and concern. Participants described this type of nursing care as uncaring, superficial or robotic, unfulfilling, yet necessary for many nurses who suffer from burnout. Lack of support and lack of time were identified as major factors that lead to emotional burnout. Caring too much meant not being able to accomplish tasks on time. Stordeur et al (2001) refers to this component of burnout as depersonalization, when nurses treat patients as

objects or act in an unfavorable manner toward them. Perhaps nurses who do not care, or who do not have a caring sense, will burnout faster than those who do exhibit a caring manner. Their careers quickly become less fulfilling, leading to a decrease in job satisfaction.

Caring as an Interpersonal Interaction. Morse et al (1990) describes caring from this perspective as a mutual endeavor between the nurse and the patient. Communication, trust, and respect occur when the parties become connected to each other. Caring is viewed as reciprocal. Caring helps the client cope, while the entire experience enriches the nurse. Just as caring is upheld as the essence of nursing, Morse et al (1990) implies that the nurse-patient relationship may be the essence of caring.

Creating a Caring Environment is an essential structure that supports the theme Nursing Care as Whole-Person Encounters. The importance of the nurse-patient relationship is central to this theme. Many behaviors and actions by the nurses included statements such as, providing health education, pre-operative and post-operative teaching, prioritizing, allowing choices, ascertaining patient perception, providing appropriate humor, and the development of trust. The essential structure Creating a Caring Environment supports this perspective, as the participants identified advocacy, the importance of the nurse-patient relationship, and providing respect and dignity to the patient as important aspects in the theme Caring: An Intrinsic Ideal. However, due to time restrictions in a fast paced environment, participants also identified in the theme Lamentations and Loss: Caring in the New Millennium, the lack of time available to get to know the patient and their families. As the workload for the nurse has increased with the shortage of staff, higher acuity, and increased technology, more tasks are given to the

nurses, making it difficult to be everywhere. Today, patients are discharged home earlier after their surgery, making it almost impossible to establish therapeutic interactions with them. The revolving door of the surgical atmosphere does not necessarily support what nurses have expressed as important aspects of delivering quality nursing care.

Participants identified that care extends beyond the patient to include the family. The theme Caring: An Intrinsic Ideal is supported by the essential structure delineating the importance of nursing the family. The nurses in my study expressed the importance of connecting with the family, as they are, more often than not, a major part of the care provided to the patient. However, nurses did express the difficulties they are faced in current practice. In the theme Lamentations and Loss: Caring in the New Millenium, nurses do not often have time to spend with the family as a result of time constraints. Family can also be demanding, thus increasing the already heavy workload for the nurse. A study by Fletcher (2001) describes how the family may be a major source of stress for the nurse, as families expect care to be the same as it was 25 years ago. Nurses are no longer allowed the luxury of time for therapeutic conversations or care techniques that comfort patients. Nurses may be seen as "care-less" in the acute care environment. Family visits, which in some facilities are extended to 24-hour visitation, may impede on the ability of the nurse to complete tasks, which are a major focus on a surgical unit. Although nurses recognize the importance of the presence of the family in the optimal recovery of the patient, family members may also be a strain on the nurses' ability to complete patient care.

Connecting and Advocating are two essential structures in the theme Caring: An Intrinsic Ideal that corresponded with the perspective of the framework. In my study,

making a connection with the patient and family was experienced as a positive. The frequency and length of time were identified as a major factor that supported or hindered the interaction. Many of the participants reflected upon stories, which described a variety of situations where the nurse and nursing staff had developed a close and interpersonal relationship with the patient. The nurse became "family" to the patient and vise versa. The relationship extended after the patient was discharged. A strong connection was established and maintained. Whether these interactions occur over time or in the last hours or moments of a patient's life, nurses remember these stories. Participants cherished "being allowed to be part of somebody's feelings" and making a connection.

Advocating for patients and family was described as a very important aspect of caring by all participants in the theme Caring: An Intrinsic Ideal. Caring includes advocating for the patient and placing their best interests first, particularly for patients who are unable to do so. Tanner and associates (Tanner, Benner, Chesla & Gordon, 1993) describe the phenomenology of knowing the patient. Knowing the patient is central to clinical judgement and it creates the possibility of advocacy. Knowing the patient is a core aspect of nursing practice and assists to maintain patient respect and dignity.

The fourth major theme, Accentuating Care: Ideal versus Reality is supported by the concerted response from the participants, which is best summarized in this statement: "Nursing is more than just tasks – it is the interaction between the nurse and the patient that is paramount" (Participant #5, Line 367-368).

Caring as a Therapeutic Intervention. The final perspective of the sensitizing framework addresses caring as a therapeutic intervention. From this perspective, the patient's goals are central and nursing care is aimed at meeting those goals. The nurse

theorists which Morse et al (1990) conceptualized into this perspective, emphasizes nursing technical competencies, skills, and the consideration of all nursing actions as a therapeutic intervention. This perspective includes a complexity of caring actions, identified by the nurse and the patient, including the provision of physical and emotional care. Therefore, task oriented skills (psychomotor) are considered actions that require a caring behavior in order to complete.

The theme Nursing Care as Whole-Person Encounters supports the reflections by the participants that nursing is not just tasks and it is not just nursing the body. It is looking after needs the patient identifies as necessary and having adequate skill and knowledge to carry out the actions required. Finding the right balance is a challenge in contemporary surgical nursing practice. All participants expressed caring in surgical practice as the ability to care for the body, mind, and spirit, which was identified as a sub-theme. Caring for the patient in a holistic way, while considering the patient's background and their environment, are important elements that contribute to the health of the patient. In the Anticipatory Needs structure, the importance of possessing keen observational, assessment, and analytical skills were identified as important principles in the delivery of quality nursing care.

Nursing activities are considered caring in relation to the way they are performed, expressing particular emotions and attitudes toward the patient by the nurse. In my study, the essential structure Creating a Caring Environment, as a positive expression, coincides with this perspective of the framework. Creating a Caring Environment included components such as making the patient comfortable, being attuned to patient needs, genuine concern for the well-being of the patient, listening, advocating, communicating,

touching, hugging, and maintaining a gentle demeanor. I believe that in order to meet the needs of the patient and create a caring environment, the nurse must be able to perform nursing activities in a manner that is truly caring. This is what makes caring unique in nursing and perhaps this is why caring may provide the basis for all nursing actions. However, within the theme Lamentations and Loss: Caring in the New Millennium, participants explained that while positive attributes are ideal, the reality of nursing persists. Factors such as lack of time, lack of support, an increase in tasking, increased acuity level, and the nursing shortage, have a negative impact on the ability of the nurse to be able to create an optimal caring environment for the patient.

Appropriateness of the Framework

The sensitizing framework provided a view for the researcher, assisting to render the perspective of the phenomenon under study. The relationship between the findings and the framework is congruent, therefore, I believe the framework was an appropriate guide for this research study. As discussed, caring is an abstract concept and to be able to grasp and interpret the lived experience of a complex concept such as caring, a broad framework was necessary. Morse et al (1990) conceptualized a vast amount of perspectives of caring into five categories, which fit very well with my findings. All themes, which were strengthened by the essential structures, corresponded and often overlapped to support the five perspectives.

Although the five perspectives by Morse et al (1990) do not describe negative caring attributes or hindrances to caring, the theme Lamentations and Loss: Caring in the New Millennium was woven into the perspectives. This helped to solidify real experiences of the nurses who work in contemporary practice and how their experiences

affect their ability to care. The themes from the findings and the five perspectives by Morse et al (1990) represent the complexity of caring, and the meaning of caring from the perspective of the nurse is valuable to assist in understanding the concept of caring (see Figure 1, p.110).

Modifications of the Framework

Morse et al (1990) explains that while divergent perspectives of this framework are conceptualized, perspectives of caring continue to remain diverse. It is important to note that, in this framework, the concept of caring included perspectives from both the nurse and the patient. Quantitative and qualitative studies are included in this conceptualization. Many of the studies compared nurses' and patients' perceptions. This qualitative research study remained committed to the perspective of the nurse. Nursing literature reveals discrepancies between the two perspectives, while identifying various caring behaviors as important. In general, the framework reveals that while patients perceive instrumental behaviors (nursing interventions and tasks) to be important, nurses consider expressive aspects of caring to be more important than nursing tasks. Participants in my study expressed caring in terms of the importance of the nurse-patient relationship and aspects that support or hinder the relationship. The nurses were emphatic in their expressions that nursing is more than just tasks.

A modification to the framework would consist of literature that included studies from the perspective of the nurse only. Studies in this area, however, have been limited or have been conducted in specialty areas.

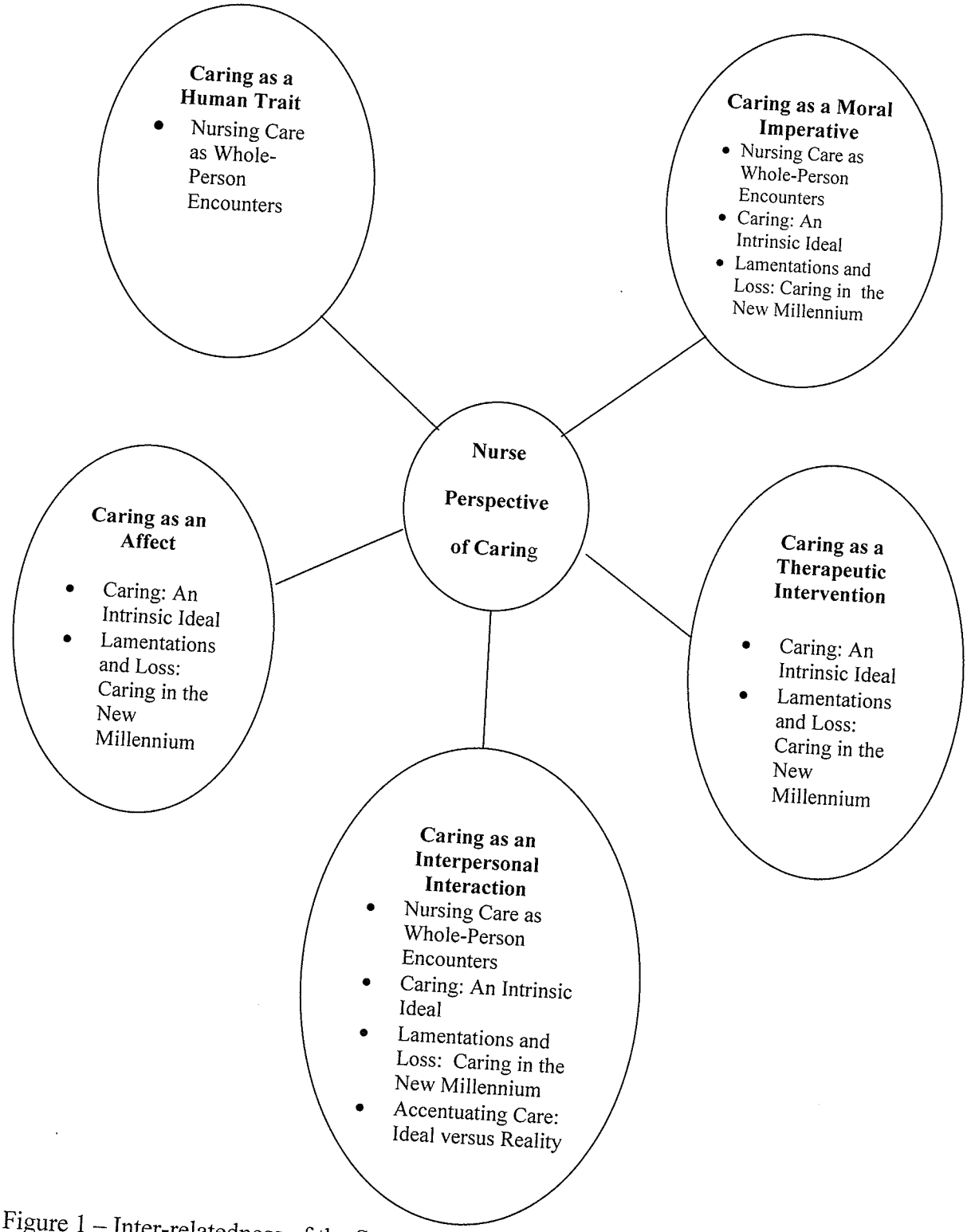

Figure 1 – Inter-relatedness of the Sensitizing Framework (Morse et al, 1990) and the Major Themes

Summary of Discussion

The discussion section of Chapter Five has considered the findings from the study in relation to the following areas: the research sample, the nursing literature and the sensitizing framework. The findings from the research have been linked together, considering how each part contributes to the total context. Through this discussion, I have arrived at a heightened awareness of the complexity of the concept of caring and the need to continue to explore and conceptualize caring in nursing, particularly in light of the dramatic changes that have occurred in the new practice environment.

Recommendations

As a result of the discussion, recommendations pertaining to the findings from the study will be examined. This section of the chapter provides recommendations in the following areas of nursing: practice and administration, education, and research.

Nursing Practice and Administration

In the theme Nursing Care as Whole-Person Encounters, participants identified Teamwork as an essential component of what caring meant to them. The nurses recognized that lack of support from co-workers and administration was a major hindrance in their ability to provide quality care. Nurses are made to believe that they have entered an autonomous profession, where they can make decisions in regards to direct patient care. In reality, nurses are often left feeling that since they have autonomy, they should not ask for assistance. Are nurses asking for help or delegating care when needed? The nurses in my study expressed that they do not have the support from the team and this has left them feeling frustrated and professionally dissatisfied in their

chosen career. The nurses expressed the need to feel part of a team, working toward positive patient outcomes.

Co-workers who are uncaring toward each other may add to low morale in the workplace. Participants expressed that when there was a lack of support from peers, they felt frustrated and disappointment. Nursing is a profession that demands teamwork. Clearly the amount of support that existed on the units directly affected the participants ability to provide care for their patients and to co-workers. These findings suggest the need for administrators to support team building among nursing staff. Opportunities for staff to attend team building seminars and strategies should exist. Employee retreats that enhance cooperative team approaches on the units should be considered.

An awareness of the importance of the team needs to be addressed from the administrative level. As discussed earlier, the elimination of middle management positions, such as the head nurse, may have added to the lack of teamwork and support. The head nurse functioned as part of the staff team, often involved in morning rounds and extended contact with patients and family. The head nurse was the anchor of the unit. Today, nurse managers and administrators are often supervising several units, which limits contact with staff and patients. A reinstatement of middle management and the head nurse model, may be a necessary strategy to improve an atmosphere of nursing cohesiveness and caring.

Support from peers, unit managers, and supervisors are the key to unlocking teamwork development and enhancement. When crucial issues and critical incidents occur, nurses need to know they have support. It is interesting that other public service professionals, such as police officers, firefighters, and ambulance attendants have routine

debriefings and access to psychologists to help them deal with distressing incidents. However, nurses are often left to their own devices, with little to no support from peers or supervisors. Hospital administrators need to become more aware of the personal and professional distress that these situations can have on staff. A combination of increasing patient acuity and decreasing budgets will inevitably escalate the number of critical incidents. Policies within the institution should provide clear directions for staff; where to go and who to talk to in times of need. The availability of debriefing teams, support groups, and regular staff meetings must be available to all staff working in acute care areas. As well, staff should have access to an advocate or counselor during critical incidents. Many large companies employ a full-time occupational health nurse or company psychologist for employees. This strategy should be considered for professionals in stressful environments, such as nursing.

Lack of peer cohesion leads to emotional exhaustion and depersonalization, and administrative leaders need to consider innovative ways to help nurses reduce work pressures and avoid burnout. Group activities for nurses outside the hospital environment should be encouraged and supported by administration and staff to enhance teamwork and elevate job satisfaction. One of the participants in my study stated that "A happy nurse is a caring nurse."

Caring for the caregiver is an important consideration to the general well-being of the nurse in the new practice environment and the future of nursing. The nurses in my study related stories about nurses who "shut down" and distanced themselves from their patients and staff as a means of coping in a stressful environment. Several participants stated that they do not want to nurse in this manner. Caring also means recognizing

burnout among co-workers and attempting to help them find the right supports to enable them to deal with these difficulties. I believe that nurses enter the nursing profession to care for people, however, it is time that nurses begin to care for each other. Creating a better workplace is not only essential to patients, but also to nurses. If nurses fail to care for each other, then how can they provide a caring environment for health consumers?

The increase in the number of tasks in the acute care environment, the unbelievable heavy workload, and the increase in the responsibility of the nurse, have left nurses feeling dissatisfied with their work. Lack of time and an increase in patient acuity have also added to the complexity of the realm in which nurses care for patients on a surgical unit, leaving them physically exhausted. These forces affecting care not only hinder quality patient care, but also places the patients at risk.

Participants described the lack of equipment available or the increase in the amount of time spent looking for supplies when needed. This was a cause of frustration as it took time away from the bedside with the patient. The nurses in my study also discussed the dramatic increase in technology and how it has seduced nurses into believing that these machines save time, when in fact trouble shooting and malfunctioning machines is common place on a surgical unit and is often time consuming for the nurses. Nurses need to be able to voice their concerns when technology takes away time from the patient and they need to be proactive in regards to new technology.

Administrative and nursing leaders need to understand the impact of the physical environment on the nurses' ability to care and begin to develop and promote support systems to assist nurses to adapt to change in the practice settings. Administrators must listen to the concerns of the nurses. Simply asking nurses "What do you need" in order to

feel satisfied about the care you are giving to patients is an essential strategy that should be employed. Administrators need to recognize the value in what nurses do and what they have to say. Nurses need to have the opportunity to voice their concerns and provide insight into job satisfaction, which is a major issue in relation to nurse retention.

Participants in this study identified personal and professional struggles that interfered with their ability to maintain quality care in an acute care environment. Nurses must be change agents within the political realm of the institution. Acting on a political level is an extension of the essence of what nursing is – caring. However, nurses tend to sit back and cope with the current environment rather than attempting to try and be heard. Nurses standing at the riverbanks are in a position to see what is occurring upstream and they need to proceed with political action in order for positive changes to occur. Nurses are strong in number, but they need to be stronger in voice.

In summary, the themes in my research reveal that nurses attempt to foster caring in the work environment to the best of their ability, despite the negative influences that occur. Nurses are an untapped resource of information in relation to what caring is and what caring is not. The nursing profession and health care administrators need to cherish these positive and negative stories in order to explore the realities of nursing in acute care today.

Nursing Education

Participants recalled demonstrations of caring, or non-caring, by nursing instructors, as having an impact on how they conceptualized caring into their practice. Nurse educators must consistently demonstrate caring interactions with patients and families. These influences can be very powerful modes of student learning. Caring is not

tangible. However, the nursing profession values caring, but how do we practice and teach caring?

Experienced nurse educators need to assume responsibility to incorporate the science of nursing with the human entity of caring in nursing curricula. If not, nursing education will diminish to a conveyor belt approach to teaching and learning. Nurse educators need to question the process of teaching and learning caring to students and seek out pedagogy that addresses caring as intrinsic to nursing.

Educators must continue to focus on the importance of the value of the nurse-patient relationship. The participants in my study emphasized nursing the whole patient and the ability to develop therapeutic interactions with patients. Nurses value patient relationships. Students need to realize that interactions with patients can provide immeasurable insight into the patient's psychological state and assist in determining planned strategies of care. This will be a challenge, considering the context of the fast paced environment and the increased number of surgical procedures that are performed. Time getting to know the patient has greatly diminished. Attention to the physical and psychological needs of the patient can not be emphasized enough in education as a necessity to uphold and practice within the standards of the profession. New graduates will need to have excellent communication and time management skills in order to work in this milieu. Nurse educators will need to develop and implement curricula that will prepare students for the realities of contemporary practice. Ensuring that students develop a level of confidence early in their education, in order to practice in this environment, will be a challenge for educators.

Reflection should continue to be part of nursing curricula. Participants in this study agreed that the reflections that were shared during the interview were somewhat cathartic. The interviews allowed them an opportunity to discuss aspects of caring that they had thought about, but had never had an opportunity to discuss. Perhaps many nurses do not recognize reflection as a formal way of thinking, however, I believe that most nurses use reflection everyday. Each participant expressed particular incidents where they often wondered "What happened to a patient" or "What could I have done differently?" Reflection of thoughts and daily events are an important strategy for problem-solving and may also assist to reduce stress by allowing reflections to be put into words – either written or verbal. As a strategy, staff must be taught and encouraged to reflect on their practice through reflective writing and share their expressions with co-workers.

While participants expressed that caring for the patient extended to the family, several participants shared that family was also seen as a burden for the nurses. Nurses need to understand the importance of family and also recognize the increased demands on families today. Economic constraints, an aging population, and chronic health problems are placing a greater strain on families. Nurses may require additional skills to assist families in the health care environment. Family nursing educational programs for practicing nurses and students need to be continued or developed. Nurses must also be proactive in educating the public about the changing face of nursing and how nurses practice their profession. This may help families understand the demands in which nurses are coping with in the contemporary setting.

Participants discussed that, as a result of time constraints, emotional exhaustion, low morale, and unsympathetic peers, mentoring students is often considered a burden to them. Sadly, many nurses refuse to mentor nursing students and new graduates. Practicing nurses need to recognize the importance of mentoring, as students are future co-workers and caregivers. Nurse administrators need to convey to staff the importance of providing an optimal learning environment for students and to be able to transcend to students that they are welcomed and are part of the team. As a strategy, administrators need to acknowledge the time and effort involved in mentoring and preceptorship of students and new graduates, and be able to offer recognition, reward, or incentive to these nurses, monetary or otherwise.

Research

As discussed in Chapter Two and Chapter Five, the numbers of studies on caring are vast, however, qualitative studies from the perspective of the nurse are limited. Studies that include general duty nurse's who work in medicine and surgery, in particular, are few. It is interesting to note that majority of practicing nurse's work on medical and surgical units. However, limited research has been conducted in this area. I would suggest further research that explores and compares medical and surgical nurse's perspectives of caring. I have wondered if these expressions are unique to surgical units, or do nurses who work on medical units have similar experiences. The perspective of acute care nurses and nurses who work in long term areas, such as palliative care, where traditional nurse-patient relationships are enhanced, should also be addressed. Real-life stories from nurses need to be valued and repeated, as nurses in all areas have insightful experiences that should be explored further. Another strategy should include qualitative

studies comparing patients' and nurses' perceptions of caring in acute care units, and also the perspective of caring from the family.

All participants in this study were women. I would recommend a study comparing the perspectives of male and female nurses working in acute care, to determine what the important essences of caring are in men versus women. Today, women, and in particular the aging workforce of nurses, occupy multiple caregiving roles; wife, mother, the caregiver of elderly parents, and of course, nurse. A study investigating the impact on the caring ability of the nurse and the various roles of caring need to be addressed.

Qualitative methods should be utilized when there is little known about the phenomenon of interest or when a new perspective is required. The literature on caring is exhaustive and often confusing. The pursuit in the exploration of caring is essential to nursing if nursing is to continue to claim that caring is the essence of nursing. Although literature on caring may appear redundant, additional qualitative studies on caring will further enhance nursing knowledge and assist to ground concepts which are complex, but are an integral part of the profession – and that is caring.

Conclusion

The discussion and recommendations have provided a thorough summary of the findings of this research study. Before concluding, I would like to briefly discuss what I have learned as a result of engaging in my research study.

My journey into this project began as a result of my own personal experiences working in acute care. I wondered if other nurses encountered similar experiences; did they feel the same way that I did? I asked participants simple questions, and I received rich descriptions of their genuine expressions and experiences working on acute care,

surgical units. After completing the interviews, I did not feel alone. Their stories echoed my own experiences. I felt that my stories belonged within the context of contemporary nursing practice and I felt an instant connection with the nurses that I interviewed. I maintain that nurses want to care deeply for their patients, that they value caring, and that caring is the essence of nursing. However, the arena to engage in caring has been a challenge. The players are the same, but the game has changed. Unfortunately, dissatisfaction in the working environment occurs when nurses are not able to meet the expectations of quality care that they have set out for their patients.

What is the future of caring? A dichotomy exists between what caring should be and what actually occurs. The attenuation of caring has been verbalized through the voices of the participants in this study. The forces and the influences ascribed by the nurses undermine caring in the new practice milieu. If this is a glimpse of the future, then the values of the nursing profession may be under siege. Caring as the central core and essence of nursing may only be a facade in contemporary practice. I maintain that as long as nurses unite and hold caring as fundamental to their profession, then it will not fade, but grow stronger.

I have learned that many nurses possess powerful stories and that their expressions need to be reflected, revisited, and written. Nurses' voices need to be heard. The privilege of listening to these stories has been an extraordinary venture. I am grateful that I was allowed to explore the meaning of caring from the perspective contemporary surgical nurses and be able to describe their experiences.

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APPENDIX A

Invitation to Participate in a Research Study

My name is Carol Enns. I am a student in the Master's program in Nursing at the University of Manitoba. As partial fulfillment of the program, I am conducting a research study entitled "Expressions of Caring by Contemporary Surgical Nurses: A Phenomenological Study". I believe that caring is an integral aspect of nursing. If the caring aspect of nursing is to remain pivotal, in light of expanding technology, a nursing shortage, increased patient acuity and an increase in day surgery facilities, then nursing as a caring practice must remain paramount. Caring has not been easily defined, and the concept of caring remains ambiguous in the nursing literature. The experience and meaning of caring from the perspective of the nurse may help to articulate the components of caring in nursing practice today.

I would like to interview approximately 10 nurses to explore their personal experiences and perceptions of caring. You are invited to participate in a research project that will seek to understand the experience of caring from the surgical nurses' perspective. Should you agree to participate, an interview will be arranged at your convenience, at a location of your choice. This interview will be audio taped and will involve a one-hour interview about your experiences of caring. I will ask you to verify the findings to clarify the information. You will be asked brief demographic information at the beginning of the interview. You will be asked to sign a consent form. All information collected will be kept strictly confidential.

Your participation is voluntary. Should you decide to participate in this study you are free to withdraw at any time with no explanation required. Your name will never be used. I am seeking out nurses who:

1. Are currently providing direct patient care
2. Have a minimum of five years experience in nursing and at least one year experience in surgical nursing
3. Are willing and able to reflect on and share expressions of caring

If you are interested in participating in this research please fill out the bottom tear off portion below and place it in the self-addressed envelope provided and mail it to me through the University of Manitoba inter-departmental mail system. If you have any further questions regarding this research study please feel free to contact me at (phone number). You may wish to contact my Thesis Committee Chairperson, Dr. Erna Schilder at (phone number).

By providing your name and phone number, you are indicating an interest in participating in the study. This means that I will contact you to pursue your interest.

I am interested in participating in this research. Please call me at your earliest convenience.

Name_____ Home Phone_____

APPENDIX B
Consent Form for Study Participants

"The Expressions of Caring by Contemporary Surgical Nurses: A Phenomenological Study"

I, _____, agree to participate in a research study exploring The Expressions of Caring by Contemporary Surgical Nurses: A Phenomenological Study. Carol Enns, a Master of Nursing student at the University of Manitoba is conducting this research. Dr. Erna Schilder, is supervising the research. I understand that approval for this study has been obtained from the Human Subject Research Ethical Review Committee at the University of Manitoba. I understand that if I have any complaints regarding any procedure of this research project, I can contact the Human Ethics Secretariat (474-7122).

I understand the purpose of this research is to explore the experience and meaning of caring from the perspective of the surgical nurse. I understand that I have met the criteria: I currently provide direct nursing care and I have been a nurse for at least five years. I have also had at least one year of surgical nursing experience.

I understand that I will be interviewed for approximately one-hour and I will have the opportunity to verify the research findings with a follow-up call from the researcher. The interview will be audio taped. I understand that my participation is voluntary and that I am free to withdraw at anytime during the interview. I may also refrain from answering any questions that I chose to not answer. I also understand that my name will never be used and that this information is strictly confidential.

I understand that by participating in the research, there will be no personal benefits gained. The data generated from the interview will be seen by the researcher, the transcriptionist, the thesis chair and the thesis committee members. I understand that the data will be stored securely in a locked placed for a period of 10 years. It will then be shredded and destroyed as confidential waste after this time. Findings from the study may be presented at research conferences and submitted for publication.

During the research process, I understand that I am free to contact the researcher, Carol Enns at (phone number) and Dr. Erna Schilder at (phone number).

I, _____, voluntarily consent to participate in this research and I have received a copy of this consent form.

_____ _____

Date Participant's Signature

_____ Researcher's Signature

APPENDIX C

Poster Invitation

RESEARCH PARTICIPATION OPPORTUNITY!

EXPRESSIONS OF CARING:
The lived experience from the surgical nurse's perspective

Would you like the opportunity to share your expressions and meaning of caring in surgical nursing practice? Do you often feel frustrated that you were not able to give the care you would like to give? Have you been nursing for at least five years? Do you have at least one year of experience working on a surgical unit?

If you have answered yes to the above questions, you may be eligible to participate in a research study designed to explore expressions and meanings of caring in contemporary surgical nursing practice.

Carol Enns, a Master of Nursing student at the University of Manitoba will be making a short presentation about this research at your upcoming staff meeting.

Date:
Time:
Location:

She will provide more detailed information on the proposed research and how you can participate.

**This research has been approved by the Human Subject Research Ethical Review Committee, University of Manitoba and the Director of Research, Health Sciences Centre.

**Participation is completely voluntary.

APPENDIX D
Letter to Nurse Manager

Carol Enns
(Address)

May 8, 2001

Nurse Manager - Unit
Health Sciences Centre
700 William Ave.
Winnipeg, Manitoba
R3E 0Z3

Dear Nurse Manager,

I am a Master of Nursing student at the Faculty of Nursing, University of Manitoba. I am conducting a research project as part of the course requirements. I am writing to you to request permission to present an invitation to the nurses on your unit to participate in my research entitled: "The Expressions of Caring by Contemporary Surgical Nurses: A Phenomenological Study". The University of Manitoba Human Subject Research Ethical Review Committee has approved my research proposal. A copy of this approval is attached.

The purpose of this study is to explore descriptions of experiences of caring from the perspective of the nurse working in contemporary surgical practice. Adequate descriptions of the meaning of caring and conditions that affect caring will be explored. This research will assist to clearly understand what caring means from the perspective of the nurse.

I would like to place posters and invitations to participate on the staff bulletin board on your unit, inviting participants to be a part of this research study. Participation is voluntary and strictly confidential. All aspects of the study will take place outside of the workplace and work hours. Results of the study may be presented at research conferences and submitted for publication following the completion of my thesis.

If you have any questions you may contact me at (phone number) or my Thesis Committee Chairperson, Dr. Erna Schilder at (phone number).

Thank you for your consideration in this matter and for your assistance. I look forward to your response.

Sincerely,

Carol Enns, RN BN, Master of Nursing Student, University of Manitoba

APPENDIX E

Demographic Information

1. Current Position_____

2. Educational Background_____

3. Years of experience as a nurse_____

4. Years of experience in surgical nursing practice_____

5. What type of surgical setting_____

6. Gender: M_____ F_____

7. Age Range: 25-35_____ 35-45_____ >45_____

APPENDIX F

Interview Guide

The questions that I am about to ask you refer to your expressions of caring. My research study invites you to share your experiences and perceptions of caring in contemporary surgical nursing practice.

Semi-structured Interview Questions

1. What does caring mean to you as a nurse?
2. I would like you to share with me an experience – a positive experience that you have had that symbolizes what caring means to you?
3. Can you share a negative experience – an experience where you were unable to provide the care you wanted to give.
4. What affects caring in your nursing practice?
5. Would you say that you value caring behavior in your practice? Can you elaborate?

Probes

1. Tell me more about your experience
2. So, you are saying_____
3. Do you want to elaborate on that?
4. So, what were your thoughts were then?
5. Can you tell me what you mean?
6. Can you tell me more?
7. There are no right or wrong answers; I would just like to get your thinking

Closure

1. Is there anything we have not discussed that you believe we should?
2. Has this reflective experience been of value? If so, how? If not, why?
3. Thank you for your time.

APPENDIX G

Health Sciences Centre Access to Research Approval Committee

Carol Enns
(Address)

October 11, 2000

The Office of the Director Of Research
Health Sciences Centre
MS7 – 820 Sherbrook Avenue
Winnipeg, MB

Dear Ms. Karen Shaw,

I am seeking approval to proceed with a Master of Nursing research project (Thesis) to be conducted at the Health Sciences Centre. Attached are all of the materials requested from your facility including a copy of the research proposal that I have submitted to the Human Subject Ethics Review Committee, University of Manitoba.

Access to the facility would include inviting nurses who are currently providing bedside nursing care and who have had experience working on a surgical unit to participate in this research project. I would like to interview 10 nurses. The interview process will not take place in the hospital. I would like to have the opportunity to contact the nurse managers on medical and surgical units and be able to provide a brief presentation about my research study to the nurses on the particular units. As mentioned, the interview will not occur during work hours or in the workplace.

I hope the attached information is sufficient. If you have any questions, please call me at (phone number).

I would like to thank you in advance for your assistance.

Sincerely,

Carol Enns RN BN
Graduate Nursing Student, University of Manitoba

APPENDIX H

THE UNIVERSITY OF MANITOBA

OFFICE OF THE PRESIDENT
Office of Research Services

244 Engineering Building
Winnipeg, Manitoba
Canada R3T 5V6

Tel: (204) 474-8418
Fax: (204) 261-0325

APPROVAL CERTIFICATE

15 November 2000

TO: **Carol Enns**
Principal Investigator

FROM: **Lorna Guse, Chair**
Education/Nursing Research Ethics Board (ENREB)

Re: **Protocol #E2000:010**
"Expressions of Caring by Contemporary Surgical Nurses: A Phenomenological Study"

Please be advised that your above-referenced protocol has received human ethics approval by the **Education/Nursing Research Ethics Board**, which is organized and operates according to the Tri-Council Policy Statement. This approval is valid for one year only.

Any significant changes of the protocol and/or informed consent form should be reported to the Human Ethics Secretariat in advance of implementation of such changes.

APPENDIX I

Thank You Letter to Participants

(Home Address)
Winnipeg, Manitoba
(Postal Code)
Date

Dear Participant:

I would like to take this opportunity to thank you for participating in my research project. I am very grateful to you for your time and effort. Your contribution to my research project was valuable.

I have now completed my Thesis. Attached you will find a summary of my project that reflects the findings. I have categorized participant comments to reflect the interviews, by creating four major themes, according to the discussion. In each major theme are several sub-themes that help to support the major categories.

I hope you that you may be able to take some time to read through the themes. I would also like to invite you to my Thesis Oral Defense, which will take place on (Date, Time and Place). If you have any comments or questions, please call me at (phone number).

Once again, thank you for your participation. It was a privilege to listen to your expressions of caring and I hope that I have retold your experiences the way you would want.

Sincerely,

Carol Enns RN BN
Graduate Nursing Student
University of Manitoba